IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
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CERTIFIED MAIL: 7007 0710 0002 7979 4008

May 21, 2010

Dallas Clinger
P O Box 420
American Falls, ID 83211

RE: Harms Memorial Hospital, provider #131304

Dear Mr. Clinger:

Based on the survey completed at Harms Memorial Hospital, on May 5, 2010, by our staff, we have determined Harms Memorial Hospital, is out of compliance with the Medicare Hospital **C240 - 42 CFR §485.627 - Organizational Structure; C270 - 42 CFR §485.635 - Provision of Services; C330 - 42 CFR §485.641 - Periodic Evaluation & QA Review**. To participate as a provider of services in the Medicare Program, a hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused these conditions to be unmet, substantially limit the capacity of Harms Memorial Hospital, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed, also, is a similar form describing State licensure deficiencies.

You have an opportunity to make corrections of those deficiencies which led to the finding of non-compliance with the Conditions of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;

- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the POC is effective in bringing the hospital into compliance, and that the hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of each form.

Such corrections must be achieved and compliance verified by this office, before June 18, 2010. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than June 11, 2010.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **June 2, 2010**.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626.

Sincerely,

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/sp
ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Kate Mitchell, CMS Region X Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131304	A. BUILDING _____ B. WING _____	05/05/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMS MEMORIAL HOSPITAL	510 ROOSEVELT STREET AMERICAN FALLS, ID 83211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	INITIAL COMMENTS The following deficiencies were cited during the complaint and Medicare recertification survey of your Critical Access Hospital and the Swing bed unit. Surveyors conducting the recertification survey were: Patrick Hendrickson, RN, HFS, Team Leader Susan Costa, RN, HFS Gary Banister, RN, HFS Acronyms used in this report include: CAH = Critical Access Hospital CEO = Chief Executive Officer CNA = Certified Nurses Assistant CPR = Cardio Pulmonary Resuscitation CS = Central Service DON = Director of Nursing ED = Emergency Department EGD = Esophagogastroduodenoscopy EMTALA = Emergency Medical Treatment and Active Labor Act ER = Emergency Room FNP = Family Nurse Practioner GI = Gastrointestinal HIS = Health Information Systems ICU = Intensive Care Unit IV =Intravenous MAR = Medication Administration Record MG = Milligrams OP = Outpatient Department OT = Occupational Therapy PI = Performance Improvement PIPs = Performance Improvement Projects PT = Physical Therapy PTA = Physical Therapy Assistant PRN = as needed QA = Quality Assurance	C 000		

RECEIVED
JUN - 7 2010
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO/ADMINISTRATOR	1 JUNE 2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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C 000	Continued From page 1 QI = Quality Indicators RN = Registered Nurse SP = Sterile Processing TB = tuberculosis X = Times	C 000		
C 154	485.608(d) PERSONNEL LICENSURE/CERTIFICATION/REGIS Staff of the CAH are licensed, certified, or registered in accordance with applicable Federal, State, and local laws and regulations. This STANDARD is not met as evidenced by: Based on review of staffing records and staff interview, it was determined the CAH failed to verify staff were properly licensed and trained for 3 of 20 facility staff and 3 of 3 contracted providers reviewed. Failure of the CAH to ensure staff were trained, licensed, certified, or registered had the potential to result in unqualified personnel working within the CAH. Findings include: 1. The facility's policies and procedures were reviewed. Policies related to ensuring contracted staff were appropriately trained, licensed, certified, or registered could not be found. The Director of Human Resources verified during an interview on 5/05/10 at 9:50 AM, that the facility did not have such a policy. Failure of the facility to develop, approve and implement policies resulted in inadequate staff training as follows: a. The CAH's Central Service Policy #6, not dated or signed, stated, "All equipment used at [CAH's name] will be cleaned/sterilized as	C 154	**C 154 485.608(d) PERSONNEL LICENSURE/ CERTIFICATION/REGIS** **11June10** 1. The CNA, ER/Endoscopy technician received training in the high level disinfection of equipment for the GI clinic at Portneuf Medical Center on 06/02/2010. The Endoscopy technician has developed a new log for the changing of the Cidex Plus which is used in our facility for high level disinfection. The Cidex Plus will be changed every 28 days as per the manufacturer's instructions. In addition the Endoscopy technician will use the Cidex Plus solution test strips prior to using the Cidex Plus solution to ensure that the glutaraldehyde concentration is above its minimum effective concentration, and the Cidex Plus will be changed if the test strip indicates that it is not above the MEC even if it has not been used for 28 days. The Endoscope technician will log the results of this test in the log book. Another performance improvement project that will be	

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C 154	Continued From page 2 appropriate to its manufacture and use." During a tour of the GI Clinic on 5/05/10 starting 12:53 PM, it was noted that the CAH used Cidex Plus to do high-level disinfection of its endoscopes. High-level disinfection is the process that kills all microbial organisms. According to Johnson & Johnson, the manufacturer of Cidex Plus, "High-level disinfection is acceptable for GI endoscopes..." A review of the package insert on the bottle of Cidex Plus showed the following recommendations: "The use period for activated CIDEX PLUS solution is up to a maximum of 28 days following activation or sooner, as indicated by the CIDEX PLUS Solution Test Strips...Solution can be reused for a period not to exceed 28 days provided the required conditions of glutaraldehyde concentration, pH, and temperature exist based upon monitoring described in directions for use...Test the solution prior to each use to assure that the glutaraldehyde concentration is above its MEC (minimum effective concentration)." In an interview 5/05/10 at 12:45 PM, with the CNA, ER/Endoscopy Technician, who did all of the endoscopy cleaning, he stated the person who trained him told him as long as test strip comes out positive there is no need to change the solution. No documentation of this training was found. The facility failed to ensure staff were trained on appropriate use of high-level disinfection chemicals necessary to ensure infection control.	C 154	instituted will be to have the equipment in the GI clinic cultured periodically between uses to monitor for bacterial growth. This corrective action will be implemented 06/05/2010 and the Director of Nursing for the hospital will be responsible to ensure compliance. 2. Letters were sent to three staffing agencies currently being used by Harms Memorial Hospital District requesting the information needed for the agency files at HMHD. The staffing agency orientation binder for the Acute Care Staff has been updated. During the week of May 24th, Alice Taylor, Acute Care DON, inserviced the staff regarding the use of agency staff at our facility. As soon as the information from the agencies is received the files in Human Resources department will be updated. Until the files are complete, the Acute Care Department will not utilize help from any staffing agency. Additionally, a new policy and procedure was developed for the "Utilization of Staffing Agency Personnel". (Please see attachment) This new policy will be presented in July to the Medical Staff for approval then to the Board of Trustees for approval.	

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C 154	Continued From page 3 b. The CAH's Central Service Policy #3, Resterilization of Supplies, and Policy #12, Resterilization of Packs and Trays, last reviewed on 1/17/08, stated an Attest was to be used with every load autoclaved. The American National Standard dated 2006, stated "Biological indicators should be used...for routine sterilizer efficacy monitoring at least weekly, but preferably every day that the sterilizer is in use." A biological indicator (spore test) is a device used to monitor the sterilization process of the autoclave. It consists of a standardized population of bacterial spores. A biological indicator monitors the autoclaving cycle and ensures that all the parameters necessary for sterilization were present during the autoclaving process. During a tour of the CAH's Sterile Processing unit on 5/4/10 starting at 2:43 PM, it was noted that instruments used for patient care were autoclaved. The CAH's "ATTEST Biological Monitoring System for Steam Sterilization" log sheets, documented the last time an Attest was run was 12/21/07. The CAH did use a chemical indicator with each load that was autoclaved. However, without the use of weekly biological indicators, in conjunction with the chemical indicators, the facility could not ensure that the parameters necessary for sterilization were present. The DON was present during the tour. She did not know what an Attest was. On 5/05/10 starting at 9:25 AM, the CS Technician was interviewed. She stated that she	C 154		

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C 154	Continued From page 4 was trained 18 years ago on how to autoclave instruments. However, she stated that she had not performed autoclaving for many years and stated she started her current CS job on 1/04/10. She stated she did not know what an Attest was or how to run one. On 5/05/10 starting at 9:30 AM, the CS Director was interviewed. She stated she did not know what an Attest was for. The facility failed to ensure staff were trained regarding Attest biological monitoring necessary to ensure infection control. 2. The Director of Human Resources, in an interview on 5/05/10 at 9:50 AM, stated the CAH worked with numerous contract agencies and not all contracted personnel had a personnel file with the CAH. Three contracts were reviewed. Missing from the contracted personnel files were documentation of licensure, CPR, orientation, TB screening, in-service attendance, and job description. She confirmed that the CAH had no individual files for any contracted personnel who had worked at the facility. The CAH failed to ensure policies and procedures were developed, approved by the Governing Body and implemented to ensure the appropriate licensing, certification, and training of all facility and contract staff.	C 154		
C 240	485.627 ORGANIZATIONAL STRUCTURE Organizational Structure This CONDITION is not met as evidenced by:	C 240	**C 240 485.627 ORGANIZATIONAL STRUCTURE:** 1. Refer to C-241 as it relates to the board of trustee oversight	**11June10**

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C 240	Continued From page 5 Based on review of policies, patient records, and staff interview, it was determined the Governing Body failed to ensure it had developed and maintained an effective organizational structure. This resulted in the CAH's inability to ensure quality health care was provided and had the potential to impact all patients seeking medical services at the CAH. Findings include: 1. Refer to C-241 as it relates to the failure of the Governing Body to ensure it had implemented and/or enforced policies governing the CAH's operations. 2. Refer to C-270, Condition of Participation: Provision of Services and related standard level deficiencies as they relate to the failure of the Governing Body to ensure patients received appropriate care and services. 3. Refer to C-330, Condition of Participation: Periodic Evaluation and Quality Assurance Review and related standard level deficiencies as they relate to failure of the Governing Body to ensure a data driven QA program was developed and implemented. The cumulative effect of these systemic practices compromised the Governing Body's ability to ensure staff provided quality health care.	C 240	of the new policies and the quarterly review of quality improvement committee. 2. Refer to C-270 as it relates to the board of trustee's responsibility over provisions of services 3. Refer to C-330 as it relates to periodic evaluation and quality assurance review.	
C 241	485.627(a) GOVERNING BODY OR RESPONSIBLE INDIVIDUAL The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing, and monitoring policies governing the CAH's total operation and for ensuring that those policies are administered so as to provide quality health care in a safe	C 241	**C 241 485.627(a) GOVERNING BODY OR RESPONSIBLE INDIVIDUAL** #1 The business office manager for the facility has been in-serviced regarding the need to treat all written	**11June10**

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C 241	Continued From page 6 environment. This STANDARD is not met as evidenced by: Based on review of policies, patient records, and staff interview, it was determined the Governing Body failed to ensure it had sufficiently developed, implemented and/or enforced policies governing the CAH's operations. This failure directly impacted 18 of 39 patients (#1, #2, #4, #5, #7, #10, #13, #12, #14, #15, #20, #22, #26, #27, #30, #31 and #33 - #39) reviewed and had the potential to impact all patients seeking medical services at the CAH. This resulted in the CAH's inability to direct staff on how to provide quality health care in a safe environment. Findings include: 1. The facility's policy "COMPLAINT/GRIEVANCE REPORTING AND INVESTIGATION," dated 3/22/05, documented, "The Complaint/Grievance Log will indicate the date and nature of final resolution." Patient #26 was a 64-year-old female who received a colonoscopy (examination of the colon through a sigmoidoscope or a colonoscope) on 5/21/08. During a phone interview, conducted on 5/04/10 at 8:30 AM, Patient #26 stated that she had written a letter of grievance to the CAH, dated 2/05/10 and received a written response from the CEO/Administrator, dated 3/05/10. The Complaint/Grievance log was reviewed on 5/04/10 at 3:00 PM. Review of grievances dated 1/08 to 5/03/10 documented no evidence of Patient #26's grievance.	C 241	complaints with regard to the billing office or process as a formal grievance, and to treat all such grievances according to the facility policy related to grievances. The business office manager will notify the quality improvement coordinator about the grievance and the grievance will be kept on the grievance log which indicates the date, nature of the grievance and the resolution of the grievance. This corrective action was implemented 06/01/2010 and will be monitored by the Director of Quality Improvement for compliance. #2 A new policy and procedure was written for the "Utilization of Staffing Agency Personnel", which outlines the necessary paperwork and certifications that must be on file for staffing agency personnel to work at Harms Memorial. Letters were sent to the three staffing agencies currently being used by Harms Memorial Hospital District requesting information needed for the agency files at HMHD. The staffing orientation binder for the Acute Care staff has been updated to include all necessary orientation and in-service documents. All hospital staff was in-serviced regarding the policy between	

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C 241	Continued From page 7 In an interview conducted with the Quality Improvement Coordinator on 5/04/10 at 3:15 PM, she stated she had no information on Patient #26's grievance. The CEO/Administrator confirmed in an interview conducted 5/04/10 at 3:25 PM, that Patient #26's information was missing from the Complaint/Grievance Log but he was aware of her concern. The Governing Body failed to ensure the CAH followed its established Complaint/Grievance policy. 2. The facility's policies and procedures were reviewed. Policies related to ensuring contracted staff were appropriately trained, licensed, certified, or registered could not be found. The Director of Human Resources verified during an interview on 5/05/10 at 9:50 AM, that the facility did not have such a policy. She stated the CAH worked with numerous contract agencies and not all contracted personnel had a personnel file with the CAH. Three contracts were reviewed. Missing from the contracted personnel files were documentation of licensure, CPR, orientation, TB screening, in-service attendance, and job description. The CAH failed to ensure policies and procedures were developed, approved by the Governing Body and implemented to ensure the appropriate licensing, certification, and training of all facility and contract staff. 3. Review of the CAH's policy and procedures, "TRANSFER POLICY," dated 4/01/05, detailed the process for the transfer of patients. The	C 241	05/25/2010 and 05/28/2010. This corrective action will be completed by 06/18/2010 and will be monitored by the Human Resources Director to ensure compliance. #3 All charts are currently audited for completeness. The chart audit tool has been updated to include checking to ensure a fully complete transfer form is in the chart for all patients who are transferred. The results of the audit will be given to the DON for review on a weekly basis, presented at the quarterly QI meeting, and presented quarterly to the governing board. All hospital nursing staff has been in-serviced on the need for each patient transferred to have a transfer form, and the need for the form to be filled out completely. This corrective action will be completed on June 1, 2010 and it will be the responsibility of Alice Taylor, DON, to implement this plan of correction. #4 A policy and procedure manual for the outpatient department was completed on May 29, 2010. The manual includes a policy for medication administration that includes antibiotic infusion rates for outpatients receiving medications, a	

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C 241	Continued From page 8 policy stated the "Consent for Transfer" form was to be completed. However, review of patient records documented Patients #1, #2, #7, #10, #30, and #31 were transferred without complete documentation of transfer orders. On 5/05/10 starting at 9:20 AM, the CAH DON was interviewed. She confirmed the patients' "Consent for Transfer" forms were either incomplete or not present in the patients' records. The CAH failed to ensure that all patients who were transferred to other facilities had appropriate documentation as defined in the written policy. 4. The facility's Emergency Department Log from 10/01/09 to 4/01/10 was reviewed and documented the CAH had 289 non-ED outpatients visits. On 5/03/10 starting at 2:30 PM, the CAH DON was interviewed. She stated the CAH had a large volume of non-emergency patients that she considered as outpatients. However, she stated that policies and procedures had not been developed for an outpatient department within the CAH. The failure to ensure appropriate policies were developed, implemented and monitored resulted in the potential to compromise patient care as follows: a. The CAH did not have an established policy for antibiotic infusion rates for outpatients receiving medications. - Patient #20's 12/23/09 nursing note documented he received Cubicin (an antibiotic) at 12:05 PM, and completed at 12:30 PM. This was 25 minutes. (Nursing 2010 Drug Handbook	C 241	policy for the use of infusion devices to be used with PICC lines and other vascular access devices, a policy for the monitoring of outpatients for complications following the administration of IV antibiotics, a policy for the changing of PICC line dressings and the management of PICC line complications, a policy for outpatient patient education, a policy that details when outpatient vital signs are to be taken, a policy for caring for outpatients with isolation precautions and a policy for the outpatient department to maintain a separate log of patients seen in the outpatient department. All hospital staff has been in-serviced regarding the new policy and procedure manual, and the changes noted above. #5 The emergency crash carts in the facility have had locks installed on them and the policy has been updated to include keeping the crash carts locked at all times when not in use. This corrective measure was implemented 06/05/2010. To ensure that medications and treatments used in the facility are maintained in date the facility will have medication monitoring done two times monthly for the emergency crash carts, ICU	

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C 241	Continued From page 9 recommended the antibiotic be infused over 30 minutes). Additionally, a nursing note on 12/29/09, Patient #20's Cubicin administration started at 8:30 AM and was completed at 8:55 AM, after an infusion of 25 minutes. On 5/05/10 starting at 9:20 AM, the DON was interviewed. She stated she was unaware the staff did not follow the 30 minute infusion recommendation. The facility failed to ensure policies to guide the staff in antibiotic infusion rates were developed, implemented and monitored. b. "Percutaneous Inserted Central Catheter" is an intravenous catheter inserted in a small vein, usually in the arm, and then advanced to a point just outside of the heart for drug administration into a much larger vessel. PICC lines are often used for long term antibiotic usage. The failure to follow specific guidelines for the management of those special IV access devices could result in a PICC becoming blocked, dislodged, or damaged. The CAH did not have a written policy for the use of infusion devices to be used with PICC lines and other vascular access devices. - Patient #20 was an 81-year-old male who had a MRSA infection. Patient #20 was seen as an outpatient on a daily basis for IV antibiotic therapy from 11/06/09 to 12/30/09. Patient #20 had a right forearm PICC. On 11/09/09, timed at 7:28 AM, a nursing note documented the antibiotic was infused by "gravity" flow. According to Lippincott Manual of Nursing Practice Eighth Edition, "Positive pressure (pump)	C 241	medication cabinet and the Hospital medication cabinet. The medication monitoring tool will list the necessary medications, the required number of the medication, and the expiration date of the medication and the labeling of opened medication. Nursing staff will use the tool to audit all medications two times monthly removing expired medications, ensuring opened medications are labeled and the medications are in the correct amount. This process will be monitored by the quality improvement coordinator and the results will be presented at the quality improvement committee meeting and to the governing board quarterly. #6 All staff was in-serviced on the need to review each chart to ensure that all medications given are accompanied by an order from the physician. All charts will be audited daily and a "medication reconciliation" will be done to ensure that all medications given have an accompanying order, and that all ordered medications were given. The in-service for all hospital staff was done 05/25/2010 and the corrective action was begun 05/26/2010. This corrective action will be monitored by	

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C 241	Continued From page 10 flushing will keep the PICC from clotting." On 5/05/10 starting at 9:20 AM, the DON was interviewed, she stated she was unaware of how the staff infused medications through PICCs. She was unable to produce a policy regarding PICC infusion management and patient care. The CAH failed to establish written policy and procedures for outpatient care of patients with vascular acces devices such as a PICC. c. The CAH did not have an established policy for the monitoring of outpatients for complications after receiving IV antibiotics. This had the potential of patients being discharged without a thorough assessment of the patients' response to the medications given. - Patient #27 was a 46-year-old male, who required IV antibiotic treatment for a throat abscess. He was seen as an outpatient on 4/12/10 and 4/13/10 for the antibiotic administration. Patient #27 was discharged on both days immediately after the antibiotic infusion had completed. Review of the records for Patient #27 did not indicate discharge vital signs were done, or a delay in his discharge to allow evaluation of tolerance to the medication given. - Patient #20 was an 81-year-old male who had a MRSA infection. Patient #20 required many outpatient visits for IV antibiotic therapy. Patient #20's nursing notes from 11/06/09 - 12/30/09 were reviewed. No less than 14 nursing notes documented his discharge (all within 5 minutes) after the completion of the antibiotic and no time provided for the evaluation of his response to the medication.	C 241	the Director of Nursing for the hospital for compliance. #7 The facilities medication administration policy has been updated to include that PRN medications need to be assessed for effectiveness. The medication administration record for all patients has been updated to include a designated area to document the effectiveness of the PRN medication given. (See attached). All hospital nursing staff has been in-serviced regarding the change in policy and the updated medication administration records. Alice Taylor, DON will be responsible for ensuring compliance with the new policy through direct chart review. The corrective measures were implemented on June 1 2010. #8 The facilities policy and procedure regarding restraints was updated to include the fact that side rails are considered a restraint and the same requirements for the use of restraints includes the use of side rails. (See attached). All hospital staff was in-serviced regarding the new policy between 05/25/2010 and 05/28/2010. The policy was implemented June 1, 2010. This corrective measure will be	

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C 241	Continued From page 11 On 5/04/10 at 11:45 AM, the CAH's Medical Director was interviewed. He stated it was a standard of practice for any patient that received antibiotics, to be held for 15 minutes after completion of the antibiotics to assess for complications. That assessment included vital signs. The CAH's outpatient department did not have a policy to direct staff in this standard of practice. The CAH failed to establish a policy for the monitoring of outpatients that had received antibiotic therapy. d. The CAH did not have an established policy for PICC dressing changes, or management of PICC complications. The failure of staff to follow a consistent and detailed process for changing the PICC dressing had the potential for increased patient infection rates, dislodgement of the catheter, and variations in staff technique. The absence of the policy for PICC complications had the potential of staff caring for patients with PICCs to not recognize when the catheter was not functioning properly. Examples include: Lippincott Manual of Nursing Practice Eighth Edition states, "Dressing change should be performed 24 hours after insertion and then weekly." Lippincott further advises, "An X-ray to determine placement of central catheter [PICC] is necessary for all devices that deliver fluid into the subclavian vein or superior vena cava." - Patient #20 was an 81-year-old male who had a right forearm PICC. In an outpatient nursing note dated 11/08/09, (untimed), noted Patient #20's PICC dressing was changed. The note stated the	C 241	monitored by Alice Taylor, DON, to ensure compliance. #9 The Central Supply technician was trained at Portneuf Medical Center on May 26, 2010 in the proper sterilization of instruments. New Attest biological indicators were ordered and implementation of their use will be started on 06//2010. All unlabeled, undated equipment will be re-sterilized upon the acquisition of new Attest biological monitoring equipment. All equipment sterilized will be labeled and dated correctly for event related needs. This corrective action will be complete by June 11, 2010. This corrective action will be monitored by the Director of Quality Improvement for continued compliance. #10 All unlabeled and undated supplies previously packaged by central supply will be re-packaged, sterilized and labeled after the facility begins using the attest system on 06/03/2010.All sterilized equipment will have labeling that includes a sterilizer load number, and a date as to when they were autoclaved. All sterilizer loads will be entered in a log book in the Sterile Processing unit that	

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C 241	Continued From page 12 PICC had pulled out to approximately 20 cm, which is approximately 8 inches. The PICC insertion site was in the right forearm, and 8 inches would not ensure that the PICC was in proper placement as a central line. There was no indication that an x-ray was done to confirm placement, or if the physician was notified regarding the PICC position change. Patient #20's record did not indicate where the placement of the PICC was initially. In a nursing note dated 11/09/09, (untimed), Patient #20 required lab work drawn, and the nurse was unable to draw blood from the PICC line, but was able to flush the line and administer the antibiotic. Inability to draw back blood from a PICC can indicate improper placement. On 5/05/10 starting at 9:20 AM, the DON was interviewed, she was unable to produce a policy or guidelines for the outpatient department staff to follow relating to PICC treatments. The DON re-confirmed there were no outpatient policies that included IV therapy and PICC line management. The CAH failed to establish written policies and procedures for the management of outpatients with PICC line complications. e. The CAH did not have an outpatient policy related to patient teaching. The lack of a policy for patient education had the potential to result in the patient not recognizing complications or side effects from therapy administered by the CAH outpatient department. Examples include: - Patient #27 was a 46-year-old male, who required IV antibiotic treatment for a throat	C 241	contains the sterilizer load numbers, dates of sterilization and contents of autoclaved instruments. This corrective measure will be completed by 06/11/2010. This corrective measure will be monitored by the Quality Improvement Coordinator for continued compliance. #11 The facility has implemented a "Discharge Summary" form that will be included in the packet of forms for all patients for the providers to use or to use as a guide for their discharge summary that includes history, physical findings, pertinent lab and radiological findings, treatments including complications, hospital course, condition on discharge, and follow-up instructions and treatment. The facilities medical staff was in-serviced regarding the items that need to be in a discharge summary, and the new form that will be available to assist them, on 5/12/2010. This corrective action was complete on 5/12/2010. This will be monitored by Mindy Earl, Director of Medical Records for compliance. #12 The Physical Therapy policy and procedure manual has been updated to include a policy that states	

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C 241	Continued From page 13 abscess. He was seen as an outpatient on 4/12/10 and 4/13/10 for the antibiotic administration. There was no indication of patient education regarding the medication and potential serious side effects which included fatal ulcerative colitis (in which the large intestine becomes inflamed and ulcerated, leading to episodes of bloody diarrhea, abdominal cramps, and fever). - Patient #20 was an 81-year-old male who had a MRSA infection. Patient #20 required many outpatient visits for IV antibiotic therapy. Review of Patient #20's nursing notes did not indicate patient education was provided regarding areas such as PICC precautions, side effects of medication, or MRSA precautions. On 5/05/10 starting at 9:20 AM, the DON was interviewed, she was unable to say if patient education was provided routinely to outpatients. She confirmed that outpatient policies to direct staff regarding patient educational needs were not developed. f. The CAH did not have an outpatient policy that detailed how and when outpatient vital signs were to be taken and recorded. This had the potential to result in the failure to monitor and assess patient response to the therapy provided by the CAH. Examples include: - Patient #20 was an 81-year-old male who had a MRSA infection. Patient #20 required many outpatient visits for IV antibiotic therapy. Review of Patient #20's outpatient visits from 12/09/09 - 12/30/09 showed failure to record discharge vital signs on no less than 9 occasions. On 5/05/10 starting at 9:20 AM, the DON was	C 241	that all evaluations and treatment provided by the physical therapy department need to have documentation of the treatment in the patient file within 48 hours from the time the service was provided. The department is currently performing a performance improvement project to ensure that all documentation is on the chart in the designated time. The police was completed 05/10/2010, and the quality improvement project started and the policy instituted on 05/24/2010 and will be ongoing. The Physical Therapist, Tom Sutton will be responsible to ensure that the facility maintains compliance with the correction. The Swingbed admission order form has been changed to include a section that a provider may check for a Physical Therapy, Occupational Therapy or Speech evaluation or therapy. Also included on the new form is a section that has been added for the nurse to "Initial when ordered or complete". The purpose of the changes to the form are to make it easier for providers and nurses to see exactly what was ordered and to make clear to anyone viewing the chart that the evaluation or the therapy was in	

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C 241	Continued From page 14 interviewed, and verbalized concern that the staff providing outpatient care had not been consistent with taking and recording of vital signs as well as completing other documentation. The CAH failed to develop a policy for taking of outpatient vital signs and the documentation of such. g. The CAH did not have a written policy for caring for outpatients with isolation precautions. The lack of a policy for the management of outpatients with highly contagious communicable diseases had the potential to expose staff, patients, and visitors to otherwise preventable illness. Examples include: - Patient # 20 was an 81-year-old male with MRSA, requiring IV therapy as an outpatient from 11/06/09 to 12/30/09. The nursing notes for Patient #20 did not indicate isolation precautions were taken. On 5/05/10 starting at 9:20 AM, the DON was interviewed. She verified that Patient #20 was being treated for MRSA. When asked about precautions the staff took in caring for Patient #20, she stated the staff had an isolation cart placed by the room. The DON was not able to verify if the staff utilized contact isolation precautions and stated she did not think the staff had used any extra measures after Patient #20 was discharged when cleaning the room that he had been in. The CAH failed to develop a policy for the management of outpatients and isolation requirements.	C 241	fact ordered. The occupational therapy department has begun a quality improvement project to monitor that they receive any orders for evaluation or therapy within 24 hours of the order being given. This corrective action will be complete June 11, 2010 and will be monitored by Alice Taylor, DON, through the use of chart reviews.	

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C 241	Continued From page 15 h. The CAH did not have written policies and procedures to define and guide the staff in the management of outpatient care. This lack of ability to separate outpatient from emergency patient status had the potential for confusion in the staff and ancillary services providing care. Further, it prevented the CAH from identification of quality indicators for improving patient outcome. Examples include: - Patient #5 was a 28-year-old male who was seen in the ED on 7/26/09. He was entered into the ED log with a notation of "OP" indicating he was an outpatient. Review of Patient #5's medical record documented two dictated notes by the FNP, each dated 7/26/09. The dictated reports were both titled "Emergency Room Report" and the face sheet described the patient type as "ER". The Emergency Room Record as well as the ER Provider Order and Documentation Record were present in the record. The "Admission Agreement" was signed by Patient #5 on 7/25/09. On 5/05/10 starting at 9:20 AM, the DON was interviewed. She stated Patient #5 was seen as an outpatient on 7/26/09 to follow up with lab work done the previous day. The DON confirmed there was no consent for services signed by Patient #5, or face sheet for the 7/26/09 visit in the medical record. The DON stated the facility practice was to put each patient being seen in to the Emergency Room Record. She stated there is no separate Outpatient Department where patients are seen, and there are no guidelines, or policies for the management of outpatients. She reviewed the "Admission Agreement" signed by Patient #5, and was not able to clarify if the form included treatment for outpatient services.	C 241		

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C 241	Continued From page 16 The CAH failed to ensure that written policies and procedures for outpatient services were developed and utilized. 5. A review of the CAH's policies & procedure titled, "Emergency Crash Carts," was not dated and not signed by the governing body. "Nursing personnel is responsible to check the crash cart two times monthly for outdates and appropriate stock levels." The policy did not provide direction to personnel when outdated medication was found. The facility failed to ensure the policy was sufficiently developed and implemented to ensure outdated drugs were removed from the crash cart as follows: On 5/03/10 at 2:30 PM, a tour of the ED was conducted. The ED unit was located off a main hallway in a high traffic area for patients, visitors, and staff. The doors of the two ED rooms were open, and the rooms were unattended. The crash cart was against the wall in clear vision to the open door. The crash cart was unlocked. Medications were in the drawer such as, Sodium Bicarbonate, Epinephrine, Atropine and IV solutions of Dextrose and Normal Saline. These medications were accessible to unauthorized personnel, patients, and visitors. In a carrier on the crash cart was an oxygen tank, with the indicator on empty, indicating the tank needed to be replaced. Additionally, in the Emergency Room, on the storage shelves was an IV solution, (1) liter bag of Lactated Ringers that expired 3/10 and Silver Nitrate sticks, one container, open, that expired 5/07.	C 241		

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C 241	Continued From page 17 On 5/03/10 starting at 4:00 PM, an ED nurse was interviewed. She verified the findings of open and accessible crash cart, expired drugs, empty oxygen tank. The ED nurse stated when the ED is unattended the rooms are under camera surveillance which are monitored at the main nursing station. Additionally, the "Emergency Crash Carts," policy did not include information regarding the locking of crash cart medications and no additional policy was found documenting that crash carts should be locked. The lack of policy was confirmed during a phone interview on 5/12/10 at 10:45 AM, with the pharmacy technician The CAH failed to follow established standards of practice and policies in management of medications. 6. The facility's policy for VERBAL AND WRITTEN ORDERS, for the Emergency Department, undated, stated: "Verbal orders for medication shall be received and recorded by the pharmacist or licensed nurse. The order will be written on the physician order sheet by the person receiving the order and noting the date and time received, the name of the licensed independent practitioner issuing the order and the receiver's name and title." However, the patients' medical records did not include physician orders for all drugs which were administered, as well as, occasions where drugs were ordered and not given. Examples include: a. Patient #2 was a 53-year-old male who was seen in the ED on 4/30/10 for lower back pain.	C 241		

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C 241	Continued From page 18 On the Provider Order and Documentation Record, dated 4/30/10, but untimed, Flomax 0.4 mg (a medication that relaxed smooth muscle and improved flow of urine), was ordered. There was no documented evidence that Patient #2 received Flomax as ordered. The ER Record contained a nursing note entry that Patient #2 was given Zofran 4 mg (medication to suppress nausea). However no order for the medication was found in Patient #2's record. On 5/05/10 starting at 9:20 AM, the DON was interviewed. She was unable to determine if Patient #2 had received the dose of Flomax. The DON could not explain why Patient #2 received the dose of Zofran without an order. b. Patient #4 was a 27-year-old female, who had inadvertently taken the wrong medication, and was seen in the ED on 7/20/09. Review of Patient #4's medical record documented a nicotine patch was administered at 4:08 PM. There was no evidence of a written order for the nicotine Patch. On 5/05/10 starting at 9:20 AM the DON was interviewed. She reviewed the record for Patient #4 and verified the absence of an order for the nicotine patch. c. Patient #10 was a 26-year-old female who was seen in the ED on 1/19/10 for pregnancy complications and cramping. The Emergency Record, dated 1/19/10 at 7:15 PM, documented Patient #10 received Ampicillin 1 gram IV (an antibiotic used as a precaution if pre-term labor was the result of an infection), and approximately 600 ml of IV fluid. There was no written orders for the IV fluid and antibiotic given.	C 241		

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C 241	Continued From page 19 On 5/05/10 starting at 9:20 AM the DON was interviewed. She reviewed the record for Patient #10, and was unable to find an order for the Ampicillin and IV fluid that was administered. d. Patient #22 was a 52-year-old male who was seen in the ED on 12/01/09 for hypoglycemia. Review of Patient #22's Emergency Room Record documented that on 12/01/09, between 12:25 and 12:40, Patient #22 received Dextrose 50% (1) ampule, Glucose Gel (1) tube (medications used for the rapid treatment of low blood sugar), and Normal Saline (IV) 400 ml. There were no written orders for the medications provided. On 5/05/10 starting at 9:20 AM the DON was interviewed. She verified the medications had been administered without a written order. The CAH failed to ensure that the policy for administration of medications was followed. 7. The facility's Medication Administration policy, that was not dated and not documented as being approved by the governing body, did not identify that PRN medications needed to be assessed for effectiveness and to document the assessment. Without consistent documentation, the facility would not be able to assess and report to the physician the effectiveness of the medications and treatments, which directly impacted patients as follows: a. Patient #15 was an 83-year-old male admitted on 4/21/10 for generalized ataxia (a neurological sign and symptom consisting of gross lack of coordination of muscle movements) and probable	C 241		

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C 241	Continued From page 20 stroke. His MAR dated 4/24 - 5/03/10, were reviewed and documented he received Ativan (a medication for anxiety) for agitation no less than 10 times. However, his record did not contain documentation of the effectiveness of the medications and treatments. Additionally, Patient #15's record included a nursing note dated 4/24/10 at 2:10 AM stated "Ativan given x 2 this shift." Patient #15's MAR only documented that Ativan was given once on 4/24/10 at 10:00 PM. A second nursing note dated 4/25/10 from 6:00 PM to 4/26/10 at 6:00 AM, stated Ativan was given twice during the shift. However, Patient #15's MAR only documented that Ativan was given once on 4/25/10 at 10:00 PM. When asked during an interview on 5/03/10 at 2:30 PM, the DON confirmed the lack of documentation and stated the effectiveness of the medications and treatments should be documented. b. Patient #14 was a 95-year-old female admitted on 4/29/10 for continued care following a hip fracture. Her MAR dated 4/29 - 5/03/10, was reviewed and documented she received prn Vicodin 14 times, prn Ativan twice, and prn Tylenol once. However, her record did not contain documentation of the effectiveness of the medications. The DON confirmed on 5/03/10 at 2:30 PM, the record did not contain information regarding the effectiveness of PRN medications. c. Patient #13 was a 66-year-old female who was admitted to the CAH on 4/05/10 for generalized	C 241		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMS MEMORIAL HOSPITAL	510 ROOSEVELT STREET AMERICAN FALLS, ID 83211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 241	Continued From page 21 ataxia. Her MAR, dated 4/05 - 4/20/10, was reviewed and documented she received prn Avitan 6 times and prn Hydrocodone 8 times. However, her record did not contain documentation of the effectiveness of the medications. The DON confirmed on 5/03/10 at 2:30 PM, the record did not contain information regarding the effectiveness of PRN medications. d. Patient #12 was a 71-year-old female who was admitted to the CAH on 2/26/10 for post care after a total knee surgery. Her MAR dated 2/26 - 3/09/10, was reviewed and documented she had received prn Percocet 29 times. However, her record did not contain documentation of the effectiveness of the medications. The DON confirmed on 5/03/10 at 2:32 PM, the record did not contain information regarding the effectiveness of PRN medications. The CAH failed to ensure records contained accurate comprehensive information including all medications administered, medication doses and information regarding the effectiveness of PRN medications. 8. The CAH's Restraint policy that was not documented as being approved by the Governing Body, defined a physical restraint as any device that restricts the freedom of movement. Patient #14 was a 95-year-old female admitted on 4/29/10 for continued care following a hip fracture. Patient #14 was observed to be confused and often tried to get out of bed. A Quality Management Memo, dated 5/01/10,	C 241		

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C 241	Continued From page 22 stated Patient #14 had fallen out of the bed at 4:45 AM. On 5/03/10 at 3:00 PM, Patient #14 was observed in bed with all four bed rails up. On 5/03/10 at 3:05 PM, Patient #14's LPN was asked why all four bed rails were up. She stated that Patient #14 had Alzheimers and the side rails helped keep her in bed. She acknowledged this was a restraint and put 2 of the four bed rails down. However the facility's Restraint policy failed to identify 4 bed rails as a restraint. The facility failed to ensure the Restraint policy was sufficiently developed. 9. The CAH's Central Service Policy #3, Resterilization of Supplies, and Policy #12, Resterilization of Packs and Trays, last reviewed on 1/17/08, stated an Attest was to be used with every load autoclaved. This policy was not followed. Examples include: The CAH's "ATTEST Biological Monitoring System for Steam Sterilization" log sheets, documented the last time an Attest was run was 12/21/07. The CAH did use a chemical indicator with each load that was autoclaved. However, without the use of weekly biological indicators, in conjunction with the chemical indicators, the facility could not ensure that the parameters necessary for sterilization were present. The DON was present during the tour. She did not know what an Attest was. On 5/05/10 starting at 9:25 AM, the CS Technician was interviewed. She stated that she was trained 18 years ago on how to autoclave	C 241		

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C 241	Continued From page 23 instruments. However, she stated that she had not preformed autoclaving for many years and stated she started her current CS job on 1/04/10. She stated she did not know what an Attest was nor how to run one. On 5/05/10 starting at 9:30 AM, the CS Director was interviewed. She stated she did not know what an Attest was for. The facility failed to ensure the Central Service Policy #3, Resterilization of Supplies, and Policy #12, Resterilization of Packs and Trays, was implemented. 10. The CAH's Central Service Policy #1, Objectives of Central Services, last reviewed on 1/17/08, stated, "Central Services will maintain an accurate record of the various processes of cleaning, disinfecting, and sterilization." During a tour of the CAH's Sterile Processing unit on 5/04/10 starting at 2:43 PM, and the ED on 5/04/10 starting at 3:00 PM, it was noted that more than 100 instruments, such as clamps, scissors and tweezers, that were autoclaved did not have a sterilizer load number, or a date written on the package as to when they were autoclaved. Additionally, the Sterile Processing unit did not have a log book that contained sterilizer load number, dates or contents of autoclaved instruments. This was confirmed by the DON during the observations. This had the potential to effect the CAH's ability to recall suspected contaminated equipment and pull outdated stock. The CAH's Central Service Policy #9, Expiration Dates, last reviewed on 1/17/08 stated, "Dates	C 241		

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C 241	Continued From page 24 will be marked in indelible ink and placed on package side which will face the person opening the package." Additionally, The CAH's Central Service Policy #8, Shelf life of packaged materials, last reviewed on 1/17/08, stated the following: "Autoclave tape, marked with the expiration date is to be placed on autoclaved packages." " Single wrapped items will have a shelf life of no greater than one month." " Double wrapped packs, basins and linens will have a shelf life of no greater than three months." " Items wrapped in plastic will have a shelf life of no greater than six months." " All outdated items will be removed from service area on day of expiration and returned to CS." The facility failed to ensure policies were followed. 11. The CAH's Rules and Regulations of the Medical Staff (Bi-Laws), dated 09/06 stated, a discharge summary should contain brief notations concerning medical complaint, history, physical findings, pertinent lab and radiology findings, treatments including complications, hospital course, condition on discharge and follow-up instructions and treatment. The Bi-Laws were not implemented as follows: - Patient #12 was a 71-year-old female who was admitted to the CAH on 2/26/10 for post care after a total knee surgery. She was discharged on 3/10/10. Patient #12's discharge summary was hand written on the record's inpatient face sheet that had the address and the billing information for Patient #12. The discharge summary did not	C 241		

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C 241	Continued From page 25 include history, physical findings, pertinent lab and radiology findings, treatments including complications, hospital course, or condition on discharge. On 5/04/10 at 2:45 PM, the CAH's HIS manager was interviewed. She reviewed Patient #12's discharge summary and stated that the lack of documentation was typical for Patient #12's physician. The facility failed to ensure discharge procedures were implemented. 12. The HIS director was interviewed on 5/04/10 starting at 1:30 PM. She stated that the CAH did not have a policy in place to direct staff as to when their evaluations and progress notes were to be recorded in the patient's record. This resulted in patient's medical records being incomplete as follows: - Patient #14 was a 95-year-old female admitted on 4/29/10 for continued care following a hip fracture. Patient #14's physician had ordered PT five times a week and an OT evaluation on 4/29/10. Patient #14's record was reviewed on 5/03/10. The record contained no documented evidence that PT had evaluated Patient #14 or had been providing PT five times a week. Additionally, the record contained no documented evidence that OT had evaluated Patient #14. On 5/03/10 at 2:17 PM, an RN called the OT/PT clinic to see if they had evaluated and were treating Patient #14. She stated that PT had evaluated Patient #14 and was treating her. However, she stated it was often that the Physical Therapist did not "turn in his evaluations and	C 241		

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C 241	Continued From page 26 notes." She further stated that OT had not received the order to evaluate Patient #14 and that was why it was not done. - Patient #15 was an 83-year-old male admitted on 4/21/10 for generalized ataxia (a neurological sign and symptom consisting of gross lack of coordination of muscle movements) and probable stroke. Patient #15's physician had ordered PT seven times a week. Patient #15's record was reviewed on 5/03/10. The record contained no documented evidence that PT had evaluated Patient #14 or had been providing PT seven times a week. On 5/03/10 starting at 2:10 PM, a PTA was interviewed. She stated that PT had evaluated Patient #15 and was treating him. However, she stated that the Physical Therapy department did not "turn in their evaluations and notes for an extended period of time." She further stated that she had worked with Patient #15 two times a week but could not provide documented evidence that anyone had provided PT services the other 5 days a week. The CAH failed to ensure policies were developed, approved by the Governing Body, implemented and monitored to ensure PT and OT services had provided and/or documented specialized rehabilitative services per physician's orders.	C 241		
C 267	485.631(c)(2)(i) PA, NP & CLINICAL NURSE SPEC RESPONSIBILITIES The physician assistant, nurse practitioner, or clinical nurse specialist performs the following functions to the extent they are not being performed by a doctor of medicine or osteopathy:	C 267	**C 267 485.631(c)(2)(i) PA, NP & CLINICAL NURSE SPEC RESPONSIBILITIES** All patients who are transferred will have their charts audited for the	**11June10**

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C 267	Continued From page 27 provides services in accordance with the CAH's policies. This STANDARD is not met as evidenced by: Based on staff interview, review of medical records and hospital policies, it was determined the hospital failed to ensure staff followed established policies related to the transfer of patients for additional medical care. This failure directly impacted 6 of 10 patients (#1, #2, #7, #10, #30, and #31) requiring transfer to other facilities whose ED records were reviewed and had the potential to impact all patients requiring a transfer to another facility. The failure of staff to follow policy had the potential to contribute to miscommunication between healthcare workers from each facility and potential negative impacts to the patients' health. Findings include: 1. Review of the CAH's policy and procedures, "TRANSFER POLICY," dated 4/01/05, detailed the process for the transfer of patients. The policy stated the "Consent for Transfer" form was to be completed. However, review of patient records documented the following: a. Patient #1 was a 16-year-old male who was brought to the ED on 4/29/10 by the police. Patient #1 complained of hearing voices telling him to harm his peers at school. A nursing note, dated 4/29/10 and timed 2:05 PM, stated the referral facility was contacted regarding a transfer. However, the nursing note did not include information that Patient #1 was accepted or the name of an accepting physician. The FNP dictated note, dated 4/29/10, stated Patient #1	C 267	inclusion of a complete transfer form. The chart audit tool was updated to include monitoring the transfer form for completeness. All hospital staff was in-serviced between 5/25/2010 to 5/28/2010 regarding when the transfer form is to be used and how to fill the form out completely. This corrective action will be completed 06/01/2010. This corrective action will be monitored by chart audits that will be presented quarterly to the Quality Improvement Committee and to the governing board.	

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C 267	Continued From page 28 must be admitted to a behavioral health unit for evaluation. On the EMERGENCY ROOM RECORD, under "Discharge" the box "other" was checked, with the name of the referral facility. The last nursing entry, timed 4:45 PM, stated: "Father, Mother, patient agree to admission, instructed to go quickly to (the referral facility), not delay." The record did not contain the "Consent for Transfer" form. On 5/05/10 starting at 9:20 AM, the CAH DON was interviewed. She confirmed the "Consent for Transfer" form was not present in Patient #1's record, and there was no evidence of a notice of acceptance by the facility or of an accepting physician. b. Patient #2 was a 53-year-old male, who presented to the ED on 4/30/10 with lower back pain. The physician who provided care for Patient #2 arranged for transfer to a receiving facility. The "Consent for Transfer form," section III, "Transfer Consent" was signed by Patient #2, but the areas to be filled in with the accepting physician, as well as the name of the facility, were left empty. On the reverse side of the form, titled "Physician Assessment and Certification" the referring physician listed the accepting physician, but not the facility. On 5/05/10 starting at 9:20 AM, the CAH DON was interviewed. She confirmed the "Consent for Transfer" form for Patient #2 included areas that were not complete. The DON stated the ED nurse was responsible for completing the paperwork. c. Patient #7 was a 22-year-old female who arrived via ambulance in active labor on 9/13/09.	C 267		

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C 267	Continued From page 29 The physician found Patient #7 to be completely dilated, with the baby's head presenting. The physician and nurse then got into the ambulance and traveled with Patient #7 to the referral facility. The medical record of Patient #7 did not contain a "Consent for Transfer." On 5/05/10 starting at 9:20 AM, the CAH DON was interviewed. She confirmed the "Consent for Transfer" form was not completed, as Patient #7 never left the ambulance. d. Patient #10 was a 26-year-old female who was 19 weeks pregnant and presented to the ED with cramping, abdominal pain and vaginal bleeding. The dictated note by the physician who provided care for Patient #10 stated the name of the accepting physician and facility she would be transferred to. The "Consent for Transfer" form was signed by Patient #10, but the areas to be filled in with the accepting physician as well as the name of the facility were left empty. On 5/05/10 starting at 9:20 AM, the CAH DON was interviewed. She confirmed the "Consent for Transfer" form for Patient #10 had areas that were not complete. e. Patient #30 was a 40-year-old female who quickly, and without assistance delivered her baby (Patient #31) in the CAH parking lot in a wheelchair on the way to the ED on 9/19/09. Patient #30 and #31 were transported to a referral facility for newborn and postpartum care. The "Consent for Transfer" was not signed by Patient #30 and the "Consent for Transfer" form was not in the record of Patient #31. On 5/05/10 starting at 9:20 AM, the CAH DON	C 267		

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C 267	Continued From page 30 was interviewed. She confirmed the Consent for Transfer form for Patient #31 was not in the record. The DON stated the ED nurse was responsible for completing the paperwork. The CAH failed to ensure that all patients who were transferred to other facilities had appropriate documentation as defined in the written policy.	C 267		
C 270	485.635 PROVISION OF SERVICES Provision of Services This CONDITION is not met as evidenced by: Based on review of policies, medical patient records, and staff interview, it was determined the CAH failed to ensure systemic practices were developed, implemented, and monitored for all patients receiving care at the facility. This failure resulted in departments which were not defined and organized and impeded the ability of the CAH to effectively provide safe, quality care. Findings include: 1. Refer to C-271 as it relates to the failure of the CAH to establish written policies and procedures related to OP services. 2. Refer to C-281 as it relates the failure of the CAH to define outpatient services and demonstrate integration of policies and procedures, oversight of infection control, and quality management. 3. Refer to C-276 as it relates to the failure of the CAH to follow established standards of practice in management of medications. The cumulative effect of these systemic practices	C 270	**C 270 485.635 PROVISIONS OF SERVICE** **11June10** 1. Refer to C-271 as it relates to the establishment by the CAH of written policies and procedures related to OP services. 2. Refer to C-281 as it relates to the CAH defining outpatient services, demonstrating integration of policies and procedures, and oversight of infection control and quality management. 3. Refer to C-276 as it relates to the CAH following established standards of practice in the management of medications.	

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C 270	Continued From page 31 compromised the CAH's ability to effectively provide safe and quality care.	C 270		
C 271	485.635(a)(1) PATIENT CARE POLICIES The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. This STANDARD is not met as evidenced by: Based on staff interview, and review of medical records and CAH policies, it was determined the CAH failed to establish written policies and procedures related to OP services. The lack of policies for outpatient services directly impacted 3 of 5 patients (#5, #20 and #27) whose outpatient records were reviewed and had the potential to impact all patients receiving outpatient services. This had the potential to compromise the quality of patient care. Findings include: 1. The facility's Emergency Department Log from 10/01/09 to 4/01/10 was reviewed and documented the CAH had 289 non-ED outpatients visits. On 5/03/10 starting at 2:30 PM, the CAH DON was interviewed. She stated the CAH had a large volume of non-emergency patients that she considered as outpatients. However, she stated that policies and procedures had not been developed for an outpatient department within the CAH. The failure to ensure appropriate policies were developed, implemented and monitored resulted in the potential to compromise patient care as follows: a. The CAH did not have an established policy for antibiotic infusion rates for outpatients	C 271	**C 271 485.635(a)(1)** **PATIENT CARE POLICIES** **11June10** A policy and procedure manual specific to the outpatient department has been completed. The policy and procedure manual contains a policy for antibiotic infusion rates, a policy for the use of infusion devices to be used with PICC lines and other vascular access devices, a policy for the monitoring of outpatients for complications after receiving antibiotics, a policy for PICC line dressing changes and the management of PICC complications, a outpatient policy for patient teaching, a policy that details how and when outpatient vital signs are to be taken and recorded, and a written policy for caring for outpatients with isolation precautions. The outpatient policy and procedure manual was completed 5/15/2010. All hospital staff were in-serviced regarding the new policy and procedure manual between 5/25/2010	

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C 271	Continued From page 32 receiving medications. This had the potential for the delivery of antibiotics over varying times, resulting in the potential for untoward side effects. - Patient #20 was an 81-year-old male who had an MRSA infection (Methicillin-resistant Staphylococcus aureus is a bacterial infection that is highly resistant to some antibiotics). In a nursing note on 12/23/09, it was documented Cubicin (an antibiotic) was given to Patient #20 at 12:05 PM, and completed at 12:30 PM. This was 25 minutes. (Nursing 2010 Drug Handbook recommended the antibiotic be infused over 30 minutes). - In a nursing note on 12/29/09, Patient #20's Cubicin administration started at 8:30 AM and was completed at 8:55 AM, after an infusion of 25 minutes. On 5/05/10 starting at 9:20 AM, the DON was interviewed. She stated she was unaware the staff did not follow the 30 minute infusion recommendation. The facility failed to ensure policies to guide the staff in antibiotic infusion rates were developed, implemented and monitored. b. "Percutaneous Inserted Central Catheter" is an intravenous catheter inserted in a small vein, usually in the arm, and then advanced to a point just outside of the heart for drug administration into a much larger vessel. PICC lines are often used for long term antibiotic usage. The failure to follow specific guidelines for the management of those special IV access devices could result in a PICC becoming blocked, dislodged, or damaged.	C 271	and 5/28/2010. The director of nursing for the hospital will be responsible for updating and maintaining the outpatient policy and procedure manual.	

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C 271	Continued From page 33 The CAH did not have a written policy for the use of infusion devices to be used with PICC lines and other vascular access devices. - Patient #20 was an 81-year-old male who had a MRSA infection. Patient #20 was seen as an outpatient on a daily basis for IV antibiotic therapy from 11/06/09 to 12/30/09. Patient #20 had a right forearm PICC. On 11/09/09, timed at 7:28 AM, a nursing note documented the antibiotic was infused by "gravity" flow. According to Lippincott Manual of Nursing Practice Eighth Edition, "Positive pressure (pump) flushing will keep the PICC from clotting." On 5/05/10 starting at 9:20 AM, the DON was interviewed, she stated she was unaware of how the staff infused medications through PICCs. She was unable to produce a policy regarding PICC infusion management and patient care. The CAH failed to establish written policy and procedures for outpatient care of patients with vascular acces devices such as a PICC. c. The CAH did not have an established policy for the monitoring of outpatients for complications after receiving IV antibiotics. This had the potential of patients being discharged without a thorough assessment of the patients' response to the medications given. - Patient #27 was a 46-year-old male, who required IV antibiotic treatment for a throat abscess. He was seen as an outpatient on 4/12/10 and 4/13/10 for the antibiotic administration. Patient #27 was discharged on both days immediately after the antibiotic infusion	C 271		

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C 271	Continued From page 34 had completed. Review of the records for Patient #27 did not indicate discharge vital signs were done, or a delay in his discharge to allow evaluation of tolerance to the medication given. - Patient #20 was an 81-year-old male who had a MRSA infection. Patient #20 required many outpatient visits for IV antibiotic therapy. Patient #20's nursing notes from the following dates reflect his immediate discharge after the completion of the antibiotic and no time provided for the evaluation of his response to the medication as follows: 11/06/09: Patient #20's antibiotics was completed at 7:55 AM. Patient #20 was discharged at 8:00 AM, 5 minutes after completion. 11/07/09: antibiotic completed at 7:45 AM, Patient #20 was discharged at 7:45 AM. 11/08/09: antibiotic completed at 7:50 AM, Patient #20 was discharged at 7:50 AM. On 11/10/09: antibiotic completed at 2:00 PM, Patient #20 was discharged at 2:00 PM. On 11/11/09: antibiotic completed at 1:20 PM, Patient #20 was discharged at 1:20 PM. On 12/17/09: antibiotic completed at 6:00 PM, Patient #20 was discharged at 6:00 PM. On 12/17/09: antibiotic completed at 4:10 PM, Patient #20 was discharged at 4:10 PM. On 12/20/10: antibiotic completed at 2:50 PM, Patient #20 was discharged at 2:50 PM.	C 271		

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C 271	Continued From page 35 On 12/24/09: antibiotic completed at 12:30 PM, Patient #20 was discharged at 12:30 PM. On 12/25/09: antibiotic completed at 11:35 AM, Patient #20 was discharged at 11:40 AM, 5 minutes after completion of the medication. On 12/26/09: antibiotic completed at 10:05 AM, Patient #20 was discharged at 10:10 AM, 5 minutes after completion of the medication. On 12/27/09: antibiotic completed at 9:20 AM, Patient #20 was discharged at 9:25 AM, 5 minutes after completion of the medication. On 12/28/09: antibiotic completed at 10:32 AM, Patient #20 was documented as discharged at 10:30 AM, which was before the antibiotic was completed. On 12/30/09: antibiotic completed at 9:40 AM, Patient #20 was discharged at 9:40 AM. On 5/04/10 at 11:45 AM, the CAH's Medical Director was interviewed. He stated it was a standard of practice for any patient that received antibiotics, to be held for 15 minutes after completion of the antibiotics to assess for complications. That assessment included vital signs. The CAH's outpatient department did not have a policy to direct staff in this standard of practice. The CAH failed to establish a policy for the monitoring of outpatients that had received antibiotic therapy. d. The CAH did not have an established policy for PICC dressing changes, or management of	C 271		

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C 271	Continued From page 36 PICC complications. The failure of staff to follow a consistent and detailed process for changing the PICC dressing had the potential for increased patient infection rates, dislodgement of the catheter, and variations in staff technique. The absence of the policy for PICC complications had the potential of staff caring for patients with PICCs to not recognize when the catheter was not functioning properly. Examples include: Lippincott Manual of Nursing Practice Eighth Edition states, "Dressing change should be performed 24 hours after insertion and then weekly." Lippincott further advises, "An X-ray to determine placement of central catheter [PICC] is necessary for all devices that deliver fluid into the subclavian vein or superior vena cava." - Patient #20 was an 81-year-old male who had a right forearm PICC. In an outpatient nursing note dated 11/08/09, (untimed), noted Patient #20's PICC dressing was changed. The note stated the PICC had pulled out to approximately 20 cm, which is approximately 8 inches. The PICC insertion site was in the right forearm, and 8 inches would not ensure that the PICC was in proper placement as a central line. There was no indication that an x-ray was done to confirm placement, or if the physician was notified regarding the PICC position change. Patient #20's record did not indicate where the placement of the PICC was initially. In a nursing note dated 11/09/09, (untimed), Patient #20 required lab work drawn, and the nurse was unable to draw blood from the PICC line, but was able to flush the line and administer the antibiotic. Inability to draw back blood from a PICC can indicate improper placement.	C 271		

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C 271	Continued From page 37 On 5/05/10 starting at 9:20 AM, the DON was interviewed, she was unable to produce a policy or guidelines for the outpatient department staff to follow relating to PICC treatments. The DON re-confirmed there were no outpatient policies that included IV therapy and PICC line management. The CAH failed to establish written policies and procedures for the management of outpatients with PICC line complications. e The CAH did not have an outpatient policy related to patient teaching. The lack of a policy for patient education had the potential to result in patient not recognizing complications or side effects from therapy administered by the CAH outpatient department. Examples include: - Patient #27 was a 46-year-old male, who required IV antibiotic treatment for a throat abscess. He was seen as an outpatient on 4/12/10 and 4/13/10 for the antibiotic administration. There was no indication of patient education regarding the medication and potential serious side effects which included fatal ulcerative colitis (in which the large intestine becomes inflamed and ulcerated, leading to episodes of bloody diarrhea, abdominal cramps, and fever). - Patient #20 was an 81-year-old male who had a MRSA infection. Patient #20 required many outpatient visits for IV antibiotic therapy. Review of Patient #20's nursing notes did not indicate patient education was provided regarding areas such as PICC precautions, side effects of medication, or MRSA precautions.	C 271		

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C 271	Continued From page 38 On 5/05/10 starting at 9:20 AM, the DON was interviewed, she was unable to say if patient education was provided routinely to outpatients. She confirmed that outpatient policies to direct staff regarding patient educational needs were not developed. f. The CAH did not have an outpatient policy that detailed how and when outpatient vital signs were to be taken and recorded. This had the potential to result in the failure to monitor and assess patient response to the therapy provided by the CAH. Examples include: - Patient #20 was an 81-year-old male who had a MRSA infection. Patient #20 required many outpatient visits for IV antibiotic therapy. Review of Patient #20's outpatient visits showed failure to record discharge vital signs as follows: 12/09/09, no discharge vital signs were noted. 12/19/09, no discharge vital signs were noted. 12/21/09, no discharge vital signs were noted. 12/24/09, no discharge vital signs were noted. 12/25/09, no discharge vital signs were noted. 12/26/09, no discharge vital signs were noted. 12/27/09, Vital signs listed on outpatient chart, but were not timed. The discharge vital signs area was blank. 12/28/09, no discharge vital signs were noted. 12/30/09, no discharge vital signs were noted. On 5/05/10 starting at 9:20 AM, the DON was interviewed, and verbalized concern that the staff providing outpatient care had not been consistent with taking and recording of vital signs as well as completing other documentation. The CAH failed to develop a policy for taking of	C 271		

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C 271	Continued From page 39 outpatient vital signs and the documentation of such. g. The CAH did not have a written policy for caring for outpatients with isolation precautions. The lack of a policy for the management of outpatients with highly contagious communicable diseases had the potential to expose staff, patients, and visitors to otherwise preventable illness. Examples include: - Patient # 20 was an 81-year-old male with MRSA, requiring IV therapy as an outpatient from 11/06/09 to 12/30/09. The nursing notes for Patient #20 did not indicate isolation precautions were taken. On 5/05/10 starting at 9:20 AM, the DON was interviewed. She verified that Patient #20 was being treated for MRSA. When asked about precautions the staff took in caring for Patient #20, she stated the staff had an isolation cart placed by the room. The DON was not able to verify if the staff utilized contact isolation precautions and stated she did not think the staff had used any extra measures after Patient #20 was discharged when cleaning the room that he had been in. The CAH failed to develop a policy for the management of outpatients and isolation requirements. h. The CAH did not have written policies and procedures to define and guide the staff in the management of outpatient care. This lack of ability to separate outpatient from emergency patient status had the potential for confusion in the staff and ancillary services providing care.	C 271		

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C 271	Continued From page 40 Further, it prevented the CAH from identification of quality indicators for improving patient outcome. Examples include: - Patient #5 was a 28-year-old male who was seen in the ED on 7/26/09. He was entered into the ED log with a notation of "OP" indicating he was an outpatient. Review of Patient #5's medical record documented two dictated notes by the FNP, each dated 7/26/09. The dictated reports were both titled "Emergency Room Report" and the face sheet described the patient type as "ER". The Emergency Room Record as well as the ER Provider Order and Documentation Record were present in the record. The "Admission Agreement" was signed by Patient #5 on 7/25/09. On 5/05/10 starting at 9:20 AM, the DON was interviewed. She stated Patient #5 was seen as an outpatient on 7/26/09 to follow up with lab work done the previous day. The DON confirmed there was no consent for services signed by Patient #5, or face sheet for the 7/26/09 visit in the medical record. The DON stated the facility practice was to put each patient being seen in to the Emergency Room Record. She stated there is no separate Outpatient Department where patients are seen, and there are no guidelines, or policies for the management of outpatients. She reviewed the "Admission Agreement" signed by Patient #5, and was not able to clarify if the form included treatment for outpatient services. The CAH failed to ensure that written policies and procedures for outpatient services were developed and utilized.	C 271		
C 276	485.635(a)(3)(iv) PATIENT CARE POLICIES	C 276	**C 276 485.635(a)(3)(iv)**	

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C 276	Continued From page 41 [The policies include the following:] rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use. This STANDARD is not met as evidenced by: Based of patient record review, staff interview and review of facility policy and procedures, it was determined that the CAH failed to follow established standards of practice and policies in management of medications. The failure to follow established standards of practice and policies had the potential for unauthorized accessibility to medications and possible administration of outdated drugs. Findings include: 1. Idaho Board of Pharmacy IDAPA 27.01.01.254.01.03 Storage of Drugs states, "All drugs shall be stored within the institutional pharmacy in designated areas equipped to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. (7-1-93)" The CAH failed to secure medications and remove expired medications from the floor stock. Findings include: a. On 5/03/10 starting at 1:16 PM, a tour of the ICU was conducted. The ICU was located off a	C 276	**PATIENT CARE POLICIES** **11June10** Staff will ensure that expired medication is removed from the floor stock by doing medication monitoring of the hospital medication cabinet and refrigerator, the ICU and ER crash carts, and the ICU medication cabinets. An audit will be done two times monthly including the name of the drug, the number of the drug to be maintained on the floor, whether the medication is in date, and whether the medication has been labeled. The central supply clerk will do an audit 2 times monthly of the medication related stock that have expiration dates including but not limited to: IV fluids, dressings, bandages, irrigation solutions etc. The audit form for non medical related stock includes the name of the stock, the number to be kept on the floor, and whether the stock is in date. Audit forms will be turned into the Director of Nursing for the hospital two times monthly. This process will be implemented by 06/11/2010. This corrective action will be monitored by the Director of Nursing for the hospital.	

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C 276	Continued From page 42 main hallway and directly in view of the nursing station. The door to the ICU was open and the crash cart was in clear view of the open door. The medication cart was located in the nurses station. In the top drawer was a plastic packet containing six Darvocet N 100 tablets that expired 2/10. The crash cart, located to the right of an occupied bed, was unlocked. The cart contained one 1000 ml 5% Dextrose intravenous solution that had expired on 5/01/10 and a box of Epinephrine 1:10000 that expired on 5/01/10. b. On 5/03/10 at 2:30 PM, a tour of the ED was conducted. The ED unit was located off a main hallway in a high traffic area for patients, visitors, and staff. The doors of the two ED rooms were open, and the rooms were unattended. The crash cart was against the wall in clear vision to the open door. The crash cart was unlocked. Medications were in the drawer such as, Sodium Bicarbonate, Epinephrine, Atropine and IV solutions of Dextrose and Normal Saline. These medications were accessible to unauthorized personnel, patients, and visitors. In a carrier on the crash cart was an oxygen tank, with the indicator on empty, indicating the tank needed to be replaced. Additionally, in the Emergency Room, on the storage shelves was an IV solution, (1) liter bag of Lactated Ringers that expired 3/10 and Silver Nitrate sticks, one container, open, that expired 5/07. On 5/03/10 starting at 4:00 PM, an ED nurse was	C 276		

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C 276	Continued From page 43 interviewed. She verified the findings of open and accessible crash cart, expired drugs, empty oxygen tank. The ED nurse stated when the ED is unattended the rooms are under camera surveillance which are monitored at the main nursing station. A review of the CAH's policies & procedure titled, "Emergency Crash Carts," was not dated and not signed by the governing body. "Nursing personnel is responsible to check the crash cart two times monthly for outdates and appropriate stock levels." The policy did not provide direction to personnel when outdated medication was found. The facility failed to ensure the policy was sufficiently developed and implemented to ensure outdated drugs were removed from the crash cart. Additionally, the "Emergency Crash Carts," policy did not include information regarding the locking of crash cart medications and no additional policy was found documenting that crash carts should be locked. The lack of policy was confirmed during a phone on 5/12/10 at 10:45 AM, with the pharmacy technician The CAH failed to follow established standards of practice and policies in management of medications.	C 276		
C 281	485.635(b)(1) DIRECT SERVICES General The CAH staff furnishes, as direct services, those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at another entry point into the health care delivery system, such as a low intensity hospital outpatient department or emergency department. These	C 281	**C 281 485.635(b)(1) DIRECT SERVICES** Harm's Memorial Hospital now has a dedicated outpatient department, with its own policy and procedure manual (see attached), and a separate log for outpatients. The policy and	**11June10**

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C 281	Continued From page 44 direct services include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions. This STANDARD is not met as evidenced by: Based on staff interview, it was determined the CAH failed to define their outpatient department, develop policies and procedures, and include infection control and quality management over site. Failure of the development of a separate differentiated department providing non-emergency care to patients had the potential to affect patient safety and outcome. Findings include: 1. On 5/03/10 at 3:30 PM, the DON was interviewed. She provided a large black book, titled "Emergency Room Log." The log contained names and details of patients seen in the ED. She explained that all patients seen in the ED were listed in the log provided, and it was noted on the page if the patient was an outpatient or emergency patient. The DON was not able to provide outpatient policies, procedures, meeting minutes or other information defining the outpatient department as a separate department. She stated there were no quality indicators, process improvements, PIPS, or record audits for the outpatient department. 2. The facility's Emergency Department Log from 10/01/09 to 4/01/10 was reviewed and documented the CAH had 289 non-ED outpatients visits. On 5/03/10 starting at 2:30 PM, the CAH DON	C 281	procedure manual contains policy's for antibiotic infusion rates, infusion devices to be used with PICC lines and other vascular access devices, monitoring of patients for complications after IV infusion of antibiotics, PICC line dressing changes and the management of PICC complications, for patient education, how and when vital signs are to be taken and recorded, and the care of outpatients with isolation precautions. The outpatient policy and procedure manual was completed on 05/15/2010 and all hospital staff was in-serviced regarding it between 05/25/2010 and 05/28/2010. The Director of Nursing for the hospital will be responsible for maintaining and updating the outpatient policy and procedure manual as needed. Corrective action to ensure that the policy for the administration of medications is followed is to add a medication reconciliation area to the chart audit that is currently done for 100% of Emergency Department and Outpatient Department charts. The medication reconciliation tool will list all medications ordered with all medications given and note any discrepancies. Any and all discrepancies will be brought to the attention of the nurse who either failed to follow an	

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C 281	Continued From page 45 was interviewed. She stated the CAH had a large volume of non-emergency patients that she considered as outpatients. However, she stated that policies and procedures had not been developed for an outpatient department within the CAH. The failure to ensure appropriate policies were developed, implemented and monitored resulted in the potential to compromise patient care as follows: a. The CAH did not have an established policy for antibiotic infusion rates for outpatients receiving medications. - Patient #20's 12/23/09 nursing note documented he received Cubicin (an antibiotic) at 12:05 PM, and completed at 12:30 PM. This was 25 minutes. (Nursing 2010 Drug Handbook recommended the antibiotic be infused over 30 minutes). Additionally, a nursing note on 12/29/09, Patient #20's Cubicin administration started at 8:30 AM and was completed at 8:55 AM, after an infusion of 25 minutes. On 5/05/10 starting at 9:20 AM, the DON was interviewed. She stated she was unaware the staff did not follow the 30 minute infusion recommendation. The facility failed to ensure policies to guide the staff in antibiotic infusion rates were developed, implemented and monitored. b. "Percutaneous Inserted Central Catheter" is an intravenous catheter inserted in a small vein, usually in the arm, and then advanced to a point just outside of the heart for drug administration into a much larger vessel. PICC lines are often used for long term antibiotic usage. The failure to	C 281	order or who failed to document a verbal order. An incident report will be filled out for all missed medications and missed documentation. Myra McDonnell, pharmacy technician, will be responsible for doing the chart audits and will present a written report regarding the rate of error to the Quality Improvement Committee and the Governing Board quarterly, whose duty it will be to ensure that staff at the hospital are complying with the medication administration policy. The facility's medication Administration policy has been updated to indentify that PRN medications need to be assessed for effectiveness, and that the effectiveness needs to be documented. The Medication Administration Record for the Hospital and Swingbed patients has been updated to include a section for the documentation of the effectiveness of PRN medications. (See attached). All hospital staff was in-serviced regarding this change to the policy and to the MAR between 05/25/2010 and 05/28/2010. This corrective action was implemented on 06/01/2010 and it will be the responsibility of the Director of Nursing for the hospital to ensure compliance with the updated policy.	

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C 281	Continued From page 46 follow specific guidelines for the management of those special IV access devices could result in a PICC becoming blocked, dislodged, or damaged. The CAH did not have a written policy for the use of infusion devices to be used with PICC lines and other vascular access devices. - Patient #20 was an 81-year-old male who had a MRSA infection. Patient #20 was seen as an outpatient on a daily basis for IV antibiotic therapy from 11/06/09 to 12/30/09. Patient #20 had a right forearm PICC. On 11/09/09, timed at 7:28 AM, a nursing note documented the antibiotic was infused by "gravity" flow. According to Lippincott Manual of Nursing Practice Eighth Edition, "Positive pressure (pump) flushing will keep the PICC from clotting." On 5/05/10 starting at 9:20 AM, the DON was interviewed, she stated she was unaware of how the staff infused medications through PICCs. She was unable to produce a policy regarding PICC infusion management and patient care. The CAH failed to establish written policy and procedures for outpatient care of patients with vascular acces devices such as a PICC. c. The CAH did not have an established policy for the monitoring of outpatients for complications after receiving IV antibiotics. This had the potential of patients being discharged without a thorough assessment of the patients' response to the medications given. - Patient #27 was a 46-year-old male, who required IV antibiotic treatment for a throat	C 281		

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C 281	Continued From page 47 abscess. He was seen as an outpatient on 4/12/10 and 4/13/10 for the antibiotic administration. Patient #27 was discharged on both days immediately after the antibiotic infusion had completed. Review of the records for Patient #27 did not indicate discharge vital signs were done, or a delay in his discharge to allow evaluation of tolerance to the medication given. - Patient #20 was an 81-year-old male who had a MRSA infection. Patient #20 required many outpatient visits for IV antibiotic therapy. Patient #20's nursing notes from 11/06/09 - 12/30/09 were reviewed. No less than 14 nursing notes documented his discharge (all within 5 minutes) after the completion of the antibiotic and no time provided for the evaluation of his response to the medication. On 5/04/10 at 11:45 AM, the CAH's Medical Director was interviewed. He stated it was a standard of practice for any patient that received antibiotics, to be held for 15 minutes after completion of the antibiotics to assess for complications. That assessment included vital signs. The CAH's outpatient department did not have a policy to direct staff in this standard of practice. The CAH failed to establish a policy for the monitoring of outpatients that had received antibiotic therapy. d. The CAH did not have an established policy for PICC dressing changes, or management of PICC complications. The failure of staff to follow a consistent and detailed process for changing the PICC dressing had the potential for increased patient infection rates, dislodgement of the	C 281		

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C 281	Continued From page 48 catheter, and variations in staff technique. The absence of the policy for PICC complications had the potential of staff caring for patients with PICCs to not recognize when the catheter was not functioning properly. Examples include: Lippincott Manual of Nursing Practice Eighth Edition states, "Dressing change should be performed 24 hours after insertion and then weekly." Lippincott further advises, "An X-ray to determine placement of central catheter [PICC] is necessary for all devices that deliver fluid into the subclavian vein or superior vena cava." - Patient #20 was an 81-year-old male who had a right forearm PICC. In an outpatient nursing note dated 11/08/09, (untimed), noted Patient #20's PICC dressing was changed. The note stated the PICC had pulled out to approximately 20 cm, which is approximately 8 inches. The PICC insertion site was in the right forearm, and 8 inches would not ensure that the PICC was in proper placement as a central line. There was no indication that an x-ray was done to confirm placement, or if the physician was notified regarding the PICC position change. Patient #20's record did not indicate where the placement of the PICC was initially. In a nursing note dated 11/09/09, (untimed), Patient #20 required lab work drawn, and the nurse was unable to draw blood from the PICC line, but was able to flush the line and administer the antibiotic. Inability to draw back blood from a PICC can indicate improper placement. On 5/05/10 starting at 9:20 AM, the DON was interviewed, she was unable to produce a policy or guidelines for the outpatient department staff to	C 281		

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C 281	Continued From page 49 follow relating to PICC treatments. The DON re-confirmed there were no outpatient policies that included IV therapy and PICC line management. The CAH failed to establish written policies and procedures for the management of outpatients with PICC line complications. e The CAH did not have an outpatient policy related to patient teaching. The lack of a policy for patient education had the potential to result in patients not recognizing complications or side effects from therapy administered by the CAH outpatient department. Examples include: - Patient #27 was a 46-year-old male, who required IV antibiotic treatment for a throat abscess. He was seen as an outpatient on 4/12/10 and 4/13/10 for the antibiotic administration. There was no indication of patient education regarding the medication and potential serious side effects which included fatal ulcerative colitis (in which the large intestine becomes inflamed and ulcerated, leading to episodes of bloody diarrhea, abdominal cramps, and fever). - Patient #20 was an 81-year-old male who had a MRSA infection. Patient #20 required many outpatient visits for IV antibiotic therapy. Review of Patient #20's nursing notes do not indicate patient education was provided regarding areas such as PICC precautions, side effects of medication, or MRSA precautions. On 5/05/10 starting at 9:20 AM, the DON was interviewed, she was unable to say if patient education was provided routinely to outpatients. She confirmed that outpatient policies to direct	C 281		

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C 281	Continued From page 50 staff regarding patient educational needs were not developed. f. The CAH did not have an outpatient policy that detailed how and when outpatient vital signs were to be taken and recorded. This had the potential to result in the failure to monitor and assess patient response to the therapy provided by the CAH. Examples include: - Patient #20 was an 81-year-old male who had a MRSA infection. Patient #20 required many outpatient visits for IV antibiotic therapy. Review of Patient #20's outpatient visits from 12/09/09 - 12/30/09 showed failure to record discharge vital signs on no less than 9 occasions. On 5/05/10 starting at 9:20 AM, the DON was interviewed, and verbalized concern that the staff providing outpatient care had not been consistent with taking and recording of vital signs as well as completing other documentation. The CAH failed to develop a policy for taking of outpatient vital signs and the documentation of such. g. The CAH did not have a written policy for caring for outpatients with isolation precautions. The lack of a policy for the management of outpatients with highly contagious communicable diseases had the potential to expose staff, patients, and visitors to otherwise preventable illness. Examples include: - Patient # 20 was an 81-year-old male with MRSA, requiring IV therapy as an outpatient from 11/06/09 to 12/30/09. The nursing notes for Patient #20 did not indicate isolation precautions	C 281		

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C 281	Continued From page 51 were taken. On 5/05/10 starting at 9:20 AM, the DON was interviewed. She verified that Patient #20 was being treated for MRSA. When asked about precautions the staff took in caring for Patient #20, she stated the staff had an isolation cart placed by the room. The DON was not able to verify if the staff utilized contact isolation precautions and stated she did not think the staff had used any extra measures after Patient #20 was discharged when cleaning the room that he had been in. The CAH failed to develop a policy for the management of outpatients and isolation requirements. h. The CAH did not have written policies and procedures to define and guide the staff in the management of outpatient care. This lack of ability to separate outpatient from emergency patient status had the potential for confusion in the staff and ancillary services providing care. Further, it prevented the CAH from identification of quality indicators for improving patient outcome. Examples include: - Patient #5 was a 28-year-old male who was seen in the ED on 7/26/09. He was entered into the ED log with a notation of "OP" indicating he was an outpatient. Review of Patient #5's medical record documented two dictated notes by the FNP, each dated 7/26/09. The dictated reports were both titled "Emergency Room Report" and the face sheet described the patient type as "ER". The Emergency Room Record as well as the ER Provider Order and Documentation Record were present in the	C 281		

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C 281	Continued From page 52 record. The "Admission Agreement" was signed by Patient #5 on 7/25/09. On 5/05/10 starting at 9:20 AM, the DON was interviewed. She stated Patient #5 was seen as an outpatient on 7/26/09 to follow up with lab work done the previous day. The DON confirmed there was no consent for services signed by Patient #5, or face sheet for the 7/26/09 visit in the medical record. The DON stated the facility practice was to put each patient being seen in to the Emergency Room Record. She stated there is no separate Outpatient Department where patients are seen, and there are no guidelines, or policies for the management of outpatients. She reviewed the "Admission Agreement" signed by Patient #5, and was not able to clarify if the form included treatment for outpatient services. The CAH failed to ensure that written policies and procedures for outpatient services were developed and utilized. 3. The facility's policy for VERBAL AND WRITTEN ORDERS, for the Emergency Department, undated, stated: "Verbal orders for medication shall be received and recorded by the pharmacist or licensed nurse. The order will be written on the physician order sheet by the person receiving the order and noting the date and time received, the name of the licensed independent practitioner issuing the order and the receiver's name and title." However, the patients' medical records did not include physician orders for all drugs which were administered, as well as, occasions where drugs were ordered and not given. Examples include:	C 281		

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C 281	Continued From page 53 a. Patient #2 was a 53-year-old male who was seen in the ED on 4/30/10 for lower back pain. On the Provider Order and Documentation Record, dated 4/30/10, but untimed, Flomax 0.4 mg (a medication that relaxed smooth muscle and improved flow of urine), was ordered. There was no documented evidence that Patient #2 received Flomax as ordered. The ER Record contained a nursing note entry that Patient #2 was given Zofran 4 mg (medication to suppress nausea). However no order for the medication was found in Patient #2's record. On 5/05/10 starting at 9:20 AM, the DON was interviewed. She was unable to determine if Patient #2 had received the dose of Flomax. The DON could not explain why Patient #2 received the dose of Zofran without an order. b. Patient #4 was a 27-year-old female, who had inadvertently taken the wrong medication, and was seen in the ED on 7/20/09. Review of Patient #4's medical record documented a nicotine patch was administered at 4:08 PM. There was no evidence of a written order for the nicotine patch. On 5/05/10 starting at 9:20 AM the DON was interviewed. She reviewed the record for Patient #4 and verified the absence of an order for the nicotine patch. c. Patient #10 was a 26-year-old female who was seen in the ED on 1/19/10 for pregnancy complications and cramping. The Emergency Record, dated 1/19/10 at 7:15 PM, documented Patient #10 received Ampicillin 1 gram IV (an antibiotic used as a precaution if pre-term labor was the result of an infection), and approximately	C 281		

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C 281	Continued From page 54 600 ml of IV fluid. There was no written orders for the IV fluid and antibiotic given. On 5/05/10 starting at 9:20 AM the DON was interviewed. She reviewed the record for Patient #10, and was unable to find an order for the Ampicillin and IV fluid that was administered. d. Patient #22 was a 52-year-old male who was seen in the ED on 12/01/09 for hypoglycemia. Review of Patient #22's Emergency Room Record documented that on 12/01/09, between 12:25 and 12:40, Patient #22 received Dextrose 50% (1) ampule, Glucose Gel (1) tube (medications used for the rapid treatment of low blood sugar), and Normal Saline (IV) 400 ml. There were no written orders for the medications provided. On 5/05/10 starting at 9:20 AM the DON was interviewed. She verified the medications had been administered without a written order. The CAH failed to ensure that the policy for administration of medications was followed. 4. The facility's Medication Administration policy, that was not dated, and not documented as being approved by the governing body, did not identify that PRN medications needed to be assessed for effectiveness and to document the assessment. Without consistent documentation, the facility would not be able to assess and report to the physician the effectiveness of the medications and treatments, which directly impacted patients as follows: a. Patient #15 was an 83-year-old male admitted on 4/21/10 for generalized ataxia (a neurological	C 281		

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C 281	Continued From page 55 sign and symptom consisting of gross lack of coordination of muscle movements) and probable stroke. His MAR dated 4/24 - 5/03/10, were reviewed and documented he received Ativan (a medication for anxiety) for agitation no less than 10 times. However, his record did not contain documentation of the effectiveness of the medications and treatments. Additionally, Patient #15's record included a nursing note dated 4/24/10 at 2:10 AM stated "Ativan given x 2 this shift." Patient #15's MAR only documented that Ativan was given once on 4/24/10 at 10:00 PM. A second nursing note dated 4/25/10 from 6:00 PM to 4/26/10 at 6:00 AM, stated Ativan was given twice during the shift. However, Patient #15's MAR only documented that Ativan was given once on 4/25/10 at 10:00 PM. When asked during an interview on 5/03/10 at 2:30 PM, the DON confirmed the lack of documentation and stated the effectiveness of the medications and treatments should be documented. b. Patient #14 was a 95-year-old female admitted on 4/29/10 for continued care following a hip fracture. Her MAR dated 4/29 - 5/03/10, was reviewed and documented she received prn Vicodin 14 times, prn Ativan twice, and prn Tylenol once. However, her record did not contain documentation of the effectiveness of the medications. The DON confirmed on 5/03/10 at 2:30 PM, the record did not contain information regarding the effectiveness of PRN medications.	C 281		

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C 281	Continued From page 56 c. Patient #13 was a 66-year-old female who was admitted to the CAH on 4/05/10 for generalized ataxia. Her MAR, dated 4/05 - 4/20/10, was reviewed and documented she received prn Avitan 6 times and prn Hydrocodone 8 times. However, her record did not contain documentation of the effectiveness of the medications. The DON confirmed on 5/03/10 at 2:30 PM, the record did not contain information regarding the effectiveness of PRN medications. d. Patient #12 was a 71-year-old female who was admitted to the CAH on 2/26/10 for post care after a total knee surgery. Her MAR dated 2/26 - 3/09/10, was reviewed and documented she had received prn Percocet 29 times. However, her record did not contain documentation of the effectiveness of the medications. The DON confirmed on 5/03/10 at 2:32 PM, the record did not contain information regarding the effectiveness of PRN medications. The CAH failed to ensure records contained accurate comprehensive information including all medications administered, medication doses and information regarding the effectiveness of PRN medications. The CAH failed to ensure that the outpatient department was established as a separate department from the ED with facility oversight and policies and procedures.	C 281		
C 297	485.635(d)(3) NURSING SERVICES All drugs, biologicals, and intravenous medications must be administered by or under	C 297	**C 297 485.635(d)(3) NURSING SERVICES** Corrective action has been taken to ensure that all medications are	**11June10**

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C 297	Continued From page 57 the supervision of a registered nurse, a doctor of medicine or osteopathy, or where permitted by State law, a physician assistant, in accordance with written and signed orders, accepted standards of practice, and Federal and State laws. This STANDARD is not met as evidenced by: Based on record review, review of facility policies and interview, it was determined the CAH failed to ensure staff administered medications to patients in accordance with pharmacy medication administration policies. Failure to follow policy and standards directly impacted 4 of 9 ED patients (#2, #4, #10 and #22), and 3 of 4 Swing Bed patients (#13, #14, and #15), whose records were reviewed. The failure to follow pharmacy medication administration policies and standards of practice had the potential to result in adverse patient outcome. Findings include: 1. The Idaho Board of Pharmacy IDAPA 27.01.01.256.01, ADMINISTRATION OF DRUGS states,"Drugs shall be administered at an institutional facility, only upon the orders, including chart orders, of those members of the medical staff who have been granted clinical privileges, or who are authorized members of the house staff, by authorized licensed facility personnel in accordance with policies and procedures specified by the appropriate committee of the facility, under applicable law and rules, and in accordance with usual and customary standards of good medical practice." The facility's policy for VERBAL AND WRITTEN ORDERS, for the Emergency Department, undated, stated: "Verbal orders for medication	C 297	administered to patients in accordance with pharmacy medication administration policies, including having all charts audited for compliance by doing a medication reconciliation between the medications that were given and the medications that were ordered. The medication reconciliation sheet will be used by the nursing staff administering medications to ensure that all medications ordered were given. The medication reconciliation sheet will also be used during the daily chart audits to re-check and ensure that all medications ordered were given. This corrective action will be completed 06/05/2010, and will be monitored by the Director of Nursing for compliance. The Medication Administration policy has been updated to include the need for PRN medications to be assessed for effectiveness and to document the effectiveness. The Medication Administration Record for inpatients and swingbed patients has been revised to include a section for documenting the effectiveness of all PRN medications given. The nursing staff was in-serviced regarding the newly instituted policy between 05/25/2010 and 05/28/2010 and the use of the police and the new MAR's was instituted at that time. The chart audit has been updated to include	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 297	Continued From page 58 shall be received and recorded by the pharmacist or licensed nurse. The order will be written on the physician order sheet by the person receiving the order and noting the date and time received, the name of the licensed independent practitioner issuing the order and the receiver's name and title." However, the patients' medical records did not include physician orders for all drugs which were administered, as well as, occasions where drugs were ordered and not given. Examples include: a. Patient #2 was a 53-year-old male who was seen in the ED on 4/30/10 for lower back pain. On the Provider Order and Documentation Record, dated 4/30/10, but untimed, Flomax 0.4 mg (a medication that relaxed smooth muscle and improved flow of urine), was ordered. There was no documented evidence that Patient #2 received Flomax as ordered. The ER Record contained a nursing note entry that Patient #2 was given Zofran 4 mg (medication to suppress nausea). However no order for the medication was found in Patient #2's record. On 5/05/10 starting at 9:20 AM, the DON was interviewed. She was unable to determine if Patient #2 had received the dose of Flomax. The DON could not explain why Patient #2 received the dose of Zofran without an order. b. Patient #4 was a 27-year-old female, who had inadvertently taken the wrong medication, and was seen in the ED on 7/20/09. Review of Patient #4's medical record documented a nicotine patch was administered at 4:08 PM. There was no evidence of a written order for the nicotine patch.	C 297	monitoring for this documentation. The chart audits are presented quarterly to the governing board and the quality improvement committee. This corrective action will be monitored by the Director of Nursing for compliance.	

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	131304	A. BUILDING _____ B. WING _____	05/05/2010

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C 297	Continued From page 59 On 5/05/10 starting at 9:20 AM the DON was interviewed. She reviewed the record for Patient #4 and verified the absence of an order for the nicotine patch. c. Patient #10 was a 26-year-old female who was seen in the ED on 1/19/10 for pregnancy complications and cramping. The Emergency Record, dated 1/19/10 at 7:15 PM, documented Patient #10 received Ampicillin 1 gram IV (an antibiotic used as a precaution if pre-term labor was the result of an infection), and approximately 600 ml of IV fluid. There was no written orders for the IV fluid and antibiotic given. On 5/05/10 starting at 9:20 AM the DON was interviewed. She reviewed the record for Patient #10, and was unable to find an order for the Ampicillin and IV fluid that was administered. d. Patient #22 was a 52-year-old male who was seen in the ED on 12/01/09 for hypoglycemia. Review of Patient #22's Emergency Room Record documented that on 12/01/09, between 12:25 and 12:40, Patient #22 received Dextrose 50% (1) ampule, Glucose Gel (1) tube (medications used for the rapid treatment of low blood sugar), and Normal Saline (IV) 400 ml. There were no written orders for the medications provided. On 5/05/10 starting at 9:20 AM the DON was interviewed. She verified the medications had been administered without a written order. The CAH failed to ensure that the policy for administration of medications was followed.	C 297		

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C 297	Continued From page 60 2. The facility's Medication Administration policy, that was not dated and not documented as being approved by the governing body, did not identify that PRN medications needed to be assessed for effectiveness and to document the assessment. Without consistent documentation, the facility would not be able to assess and report to the physician the effectiveness of the medications and treatments, which directly impacted patients as follows: a. Patient #15 was an 83-year-old male admitted on 4/21/10 for generalized ataxia (a neurological sign and symptom consisting of gross lack of coordination of muscle movements) and probable stroke. His MAR dated 4/24 - 5/03/10, were reviewed and documented he received Ativan (a medication for anxiety) for agitation as follows: - 4/26/10 at 3:50 PM. - 4/26/10 at 10:50 PM. - 4/27/10 at 11:53 PM. - 4/28/10 at 5:00 PM. - 4/28/10 at 11:00 PM. - 5/01/10 at 7:05 AM. - 5/02/10 at 3:30 PM. - 5/02/10 at 9:30 PM. - 5/03/10 at 7:30 AM. - 5/03/10 at 2:10 PM. However, his record did not contain documentation of the effectiveness of the medications and treatments. Additionally, Patient #15's record included a nursing note dated 4/24/10 at 2:10 AM stated "Ativan given x 2 this shift." Patient #15's MAR only documented that Ativan was given once on 4/24/10 at 10:00 PM.	C 297		

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C 297	Continued From page 61 A second nursing note dated 4/25/10 from 6:00 PM to 4/26/10 at 6:00 AM, stated Ativan was given twice during the shift. However, Patient #15's MAR only documented that Ativan was given once on 4/25/10 at 10:00 PM. When asked during an interview on 5/03/10 at 2:30 PM, the DON confirmed the lack of documentation and stated the effectiveness of the medications and treatments should be documented. b. Patient #14 was a 95-year-old female admitted on 4/29/10 for continued care following a hip fracture. Her MAR dated 4/29 - 5/03/10, was reviewed and documented she received the following: - 4/29/10 at 5:45 PM. Vicodin (a medication for pain), 2 tablets were given for pain. - 4/29/10 at 6:00 PM. Ativan was given for agitation. - 4/30/10 at 3:00 AM. Vicodin 2 tablets, were given for pain. - 4/30/10 at 10:50 AM. Vicodin 1 tablet, was given for pain. - 4/30/10 at 4:15 PM. Vicodin 1 tablet, was given for pain. - 4/30/10 at 7:25 PM. Vicodin 1 tablet, was given for pain. - 5/01/10 at 8:30 AM. Vicodin 1 tablet, was given for pain. - 5/01/10 at 9:55 AM. Vicodin 1 tablet, was given for pain. - 5/01/10 at 4:10 PM. Vicodin 2 tablets, were given for pain. - 5/01/10 at 10:30 PM. Vicodin 2 tablets, were given for pain.	C 297		

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C 297	Continued From page 62 - 5/02/10 at 8:00 AM. Vicodin, no dose listed, was given for pain. - 5/02/10 at 3:00 PM. Vicodin, no dose listed, was given for pain. - 5/02/10 at 9:00 PM. Vicodin, no dose listed, was given for pain and Ambien no dose listed, was documented as being given for restlessness. - 5/03/10 at 7:15 AM. Vicodin 1 tablet, was given for pain. - 5/03/10 at 7:15 AM. Tylenol 650 mg, was given for pain. - 5/03/10 at 12:30 PM. Vicodin 2 tablets, were given for pain. - 5/03/10 at 7:45 PM. Ativan was given for anxiety. However, her record did not contain documentation of the effectiveness of the medications. The DON confirmed on 5/03/10 at 2:30 PM, the record did not contain information regarding the effectiveness of PRN medications. c. Patient #13 was a 66-year-old female who was admitted to the CAH on 4/05/10 for generalized ataxia. Her MAR, dated 4/05 - 4/20/10, was reviewed and documented she received the following: - 4/05/10 at 9:00 PM. Ativan was given for anxiety. - 4/06/10 at 9:00 PM. Ativan was given for anxiety. - 4/07/10 at 9:00 PM. Ativan was given for anxiety. - 4/08/10 at 9:00 PM. Ativan was given for anxiety. - 4/10/10 at 9:00 PM. Ativan was given for "sleeplessness." - 4/10/10 at 9:00 PM. Hydrocodone (a medication	C 297		

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C 297	Continued From page 63 for pain), no dose was listed. - 4/11/10 at 9:00 PM. Ativan was given for "sleeplessness." - 4/13/10 at 10:31 PM. Hydrocodone 1 tablet, was given for pain. - 4/17/10 at 1:30 AM. Hydrocodone, no dose listed, was given for pain. - 4/17/10 at 11:30 PM. Hydrocodone 1 tablet, was given for pain. - 4/18/10 at 9:00 PM. Hydrocodone 1 tablet, was given for pain. - 4/19/10 at 4:11 AM. Hydrocodone 1 tablet, was given for pain. - 4/19/10 at 10:30 PM. Hydrocodone 1 tablet, was given for pain. - 4/20/10 at 5:05 AM. Hydrocodone 1 tablet, was given for pain. However, her record did not contain documentation of the effectiveness of the medications. The DON confirmed on 5/03/10 at 2:30 PM, the record did not contain information regarding the effectiveness of PRN medications. d. Patient #12 was a 71-year-old female who was admitted to the CAH on 2/26/10 for post care after a total knee surgery. Her MAR dated 2/26 - 3/09/10, was reviewed and documented she had received the following: - 2/26/10 at 8:00 AM. Percocet (a medication for pain), 2 tablets were given. - 2/26/10 at 8:00 PM. Percocet 2 tablets, were given for pain. - 2/27/10 at 8:00 PM. Percocet 1 tablet, was given for pain. - 2/28/10 at 6:50 AM. Percocet 1 tablet, was given for pain. - 2/28/10 at 12:30 PM. Percocet 1 tablet, was	C 297	**C 330 485.641** **PERIODIC EVALUATION & QA REVIEW** 1. A policy guiding the use of incident reports for the facility was written and included in the policy and procedure manual. (See attached). The policy describes where the form is located, the information to be included on the form, different categories of incidents, and the procedure for analyzing the event to develop and implement processes to improve care. All hospital staff was in-serviced regarding the new policy and when to use the incident report on 05/25/2010. The Director of Nursing for the hospital will do chart reviews to determine that in the event of an incident the form is filled out and presented to the proper management personnel so that problems can be identified and processes developed to prevent adverse events and improve quality. This corrective action was completed on 05/25/2010 and the Director of Nursing for the hospital will be responsible for ensuring continued adherence to the policy by staff. 2. Training has been scheduled for the Endoscopy technician for 06/02/2010	**11June10**

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C 297	Continued From page 64 given for pain. - 2/28/10 at 5:00 PM. Percocet 1 tablet, was given for pain. - 2/28/10 at 9:00 PM. Percocet 1 tablet, was given for pain. - 3/01/10 at 8:00 AM. Percocet 1 tablet, was given for pain. - 3/01/10 at 1:00 PM. Percocet 1 tablet, was given for pain. - 3/01/10 at 8:00 PM. Percocet 1 tablet, was given for pain. - 3/02/10 at 6:30 AM. Percocet 1 tablet, was given for pain. - 3/02/10 at 12:30 PM. Percocet 1 tablet, was given for pain. - 3/02/10 at 6:30 PM. Percocet 1 tablet, was given for pain. - 3/03/10 at 8:00 PM. Percocet, no dose listed, was given for pain. - 3/04/10 at 1:30 PM. Percocet, no dose listed, was given for pain. - 3/04/10 at 9:00 PM. Percocet, no dose listed, was given for pain. - 3/05/10 at 8:00 AM. Percocet, no dose listed, was given for pain. - 3/05/10 at 1:30 PM. Percocet, no dose listed, was given for pain. - 3/06/10 at 8:00 AM. Percocet, no dose listed, was given for pain. - 3/06/10 at 2:45 PM. Percocet, no dose listed, was given for pain. - 3/06/10 at 8:45 PM. Percocet, no dose listed, was given for pain. - 3/07/10 at 7:30 AM. Percocet 1 tablet, was given for pain. - 3/07/10 at 2:00 PM. Percocet 1 tablet, was given for pain. - 3/07/10 at 8:00 PM. Percocet 1 tablet, was given for pain.	C 297	to review cleaning processes for all aspects of the GI clinic. The Endoscopy technician has a new log book for the changing of the Cidex Plus which is used in our facility for high level disinfection of the GI endoscopes. The log will be used to monitor the date that the Cidex Plus solution is activated. The manufacturer of the disinfectant recommends it be used for 28 days, so the log will be checked prior to each use of the Cidex Plus to ensure it is still within the 28 day period. In addition the Cidex Plus will be checked prior to its use every time it is used with the Cidex Plus Solution Test Strips to ensure that the glutaraldehyde concentration is above its minimum effective concentration. The strip indicates if the solution is still within the minimum effective concentration, and if it is not new Cidex Plus will be activated for cleaning, even if it is not yet over 28 days old. The log will include the testing of the Cidex Plus Solution prior to its use and will reflect the results of the strip testing. A further quality improvement project for the GI clinic will be to have random cultures done of the previously sterilized equipment between uses to monitor for growth of bacteria. All of these quality improvement processes will be presented	

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C 297	Continued From page 65 - 3/08/10 at 7:30 AM. Percocet 1 tablet, was given for pain. - 3/08/10 at 1:45 PM. Percocet 1 tablet, was given for pain. - 3/08/10 at 8:30 PM. Percocet 1 tablet, was given for pain. - 3/09/10 at 7:30 AM. Percocet 1 tablet, was given for pain. - 3/09/10 at 1:15 PM. Percocet 1 tablet, was given for pain. However, her record did not contain documentation of the effectiveness of the medications. The DON confirmed on 5/03/10 at 2:32 PM, the record did not contain information regarding the effectiveness of PRN medications. The CAH failed to ensure records contained accurate comprehensive information including all medications administered, medication doses and information regarding the effectiveness of PRN medications.	C 297	quarterly to the quality improvement committee and to the governing board. These corrective measures will be completely implemented by 06/05/2010, and monitored by the Director of Nursing for the hospital to ensure compliance. 3. The CS technician had training in packaging, sterilization, labeling and QI indicators for disinfection of the facilities instruments. She was trained at Portneuf Medical center on 05/27/2010. The facility has ordered biological testing indicators for use when autoclaving so that each time autoclaving is done it will have a chemical and biological indicator to ensure that the parameters necessary for sterilization are met. She has developed a log to accompany each load of sterilizing done in the autoclave indicating the results of the biological and chemical test. All previously packaged instruments that were autoclaved before the facility used biological indicators in conjunction with the chemical indicators will be re-sterilized. All instruments sterilized will be labeled with date, contents and load number. The log will include the load number, contents and date, so event related monitoring can occur to recall	
C 330	485.641 PERIODIC EVALUATION & QA REVIEW Periodic Evaluation and Quality Assurance Review This CONDITION is not met as evidenced by: Based on observation, staff interview, and review of medical records, facility policies, and QA/QI documents, it was determined the CAH failed to ensure a comprehensive data driven QA program was developed and implemented. This resulted in missed opportunities for improved patient care. Findings include:	C 330		

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C 330	Continued From page 66 1. Refer to C-336 as it relates to the facility's failure to ensure the QA program had analyzed all patient adverse events. 2. Refer to C-337 as it relates to the facility's failure to ensure the QA program had evaluated the quality and appropriateness of all patient care services offered. 3. Refer to C-281 as it relates to the facility's failure to define outpatient services and demonstrate integration of quality management. The cumulative effect of these systemic practices compromised the QA program's ability to effectively evaluate the quality and appropriateness of all patient care services offered.	C 330	suspected contaminated equipment and to pull outdated stock. This corrective process will be completed by 06/08/2010. The corrective process will be monitored by the Director of Quality Improvement for continued compliance, and all quality improvement data for the Central Processing Unit will be presented at the quarterly quality improvement meeting and to the governing board.	
C 336	485.641(b) QUALITY ASSURANCE The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that -- This STANDARD is not met as evidenced by: Based on staff interview and review of patient records and Quality Management Memos, it was determined the CAH failed to ensure the QA program had analyzed all patient adverse events for 2 of 39 patients (#13 and #20) whose records were reviewed. This resulted in the inability of the CAH to develop and implement processes to improve care. Findings include:	C 336	**C 336 485.641(b)** **QUALITY ASSURANCE** A policy guiding the use of incident reports for the facility was written and included in the policy and procedure manual. (See attached). The policy describes where the form is located, the information to be included on the form, different categories of incidents, and the procedure for analyzing the event to develop and implement processes to improve care. All hospital staff was in-serviced regarding the new policy and when to use the incident report between 05/25/2010 and 05/28/2010. The	**11June10**

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C 336	Continued From page 67 1. Patient #13 was a 66-year-old female who was admitted to the CAH on 4/05/10 for generalized ataxia (a neurological sign and symptom consisting of gross lack of coordination of muscle movements). A nursing note dated 4/09/10, that was timed 6:00 AM - 6:00 PM, stated the nurse had found a Norco (a narcotic medication used for pain management), on Patient #13's bedside table that Patient #13's husband brought in. Review of the CAH's Quality Management Memos on 5/04/10 did not document the nurse had notified the QA department of the incident. On 5/04/10 starting at 11:18 AM, the QA Manager was interviewed. She confirmed a Quality Management Memo had not been completed out for the incident and stated one should have been. 2. Patient #20 was an 81-year-old male who had a right forearm PICC. An outpatient nursing note, dated 11/08/09, that was untimed, stated Patient #20's PICC dressing was changed, and the note stated the PICC had pulled out to 20 cm, which is approximately 8 inches. Patient #20's PICC insertion site was in the right forearm, and 8 inches would not ensure that the PICC was in proper placement as a central line. On 5/05/10 starting at 9:20 AM, the DON was interviewed. She stated no incident report had been completed regarding Patient #20's PICC line dislodgement. The CAH failed to ensure that all events were reported to the quality improvement program so they could be analyzed and steps could be taken to prevent further incidents.	C 336	Director of Nursing for the hospital will do chart reviews to determine that in the event of an incident the form is filled out and presented to the proper management personnel so that problems can be identified and processes developed to prevent adverse events and improve quality. This corrective action was completed on 05/25/2010 and the Director of Nursing for the hospital will be responsible for ensuring continued adherence to the policy by staff.	
C 337	485.641(b)(1) QUALITY ASSURANCE	C 337	**C 337 485.641(b)(1)**	

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C 337	Continued From page 68 The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that- all patient care services and other services affecting patient health and safety are evaluated. This STANDARD is not met as evidenced by: Based on observation, staff interview, and review of medical records, facility policies, PIP and QI documents, it was determined the CAH failed to ensure its QA program had evaluate the quality and appropriateness of all patient care services and departments within the CAH. This directly impacted 7 of 7 patients (Patients #33 thru #39), who received endoscopy services and had the potential to impact all patients seeking medical care. The lack of quality oversight had the potential to affect patient safety. Findings include: 1. Review of the CAH's QI log and PIPs for 2009, and the first quarter of 2010 documented that the GI Laboratory, Sterile Processing, PT services, OT services, and Out Patient services, did not have QIs being collected and PIPs. On 5/05/10 at 9:15 AM, the Director of Quality Improvement confirmed that the GI Laboratory, Sterile Processing, PT services, OT services, and Out Patient services, did not have QIs being collected and PIPs. The lack of an organized QA program resulted in the inability of the CAH to evaluate and improve its processes. Because of the absence of Quality Improvement oversight the following	C 337	**485.641(b)(1)** **QUALITY ASSURANCE** 1. Training has been scheduled for the Endoscopy technician for 06/02/2010 to review cleaning processes for all aspects of the GI clinic. The Endoscopy technician has a new log book for the changing of the Cidex Plus which is used in our facility for high level disinfection of the GI endoscopes. The log will be used to monitor the date that the Cidex Plus solution is activated. The manufacturer of the disinfectant recommends it be used for 28 days, so the log will be checked prior to each use of the Cidex Plus to ensure it is still within the 28 day period. In addition the Cidex Plus will be checked prior to its use every time it is used with the Cidex Plus Solution Test Strips to ensure that the glutaraldehyde concentration is above its minimum effective concentration. The strip indicates if the solution is still within the minimum effective concentration, and if it is not new Cidex Plus will be activated for cleaning, even if it is not yet over 28 days old. The log will include the testing of the Cidex Plus Solution prior to its use and will reflect the results of the strip testing. A further quality improvement project for the GI clinic	**11June10**

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HARMS MEMORIAL HOSPITAL	510 ROOSEVELT STREET AMERICAN FALLS, ID 83211

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C 337	Continued From page 69 resulted: a. During a tour of the GI Clinic on 5/05/10 starting 12:53 PM,it was noted that the CAH used Cidex Plus to do high-level disinfection of its endoscopes. High-level disinfection is the process that killed all microbial organisms. According to Johnson & Johnson, the manufacturer of Cidex Plus, "High-level disinfection is acceptable for GI endoscopes..." Review of the package insert on the bottle of Cidex Plus showed the following recommendations: "The use period for activated CIDEX PLUS solution is up to a maximum of 28 days following activation or sooner, as indicated by the CIDEX PLUS Solution Test Strips." "Solution can be reused for a period not to exceed 28 days provided the required conditions of glutaraldehyde concentration, pH, and temperature exist based upon monitoring described in directions for use..." According to the Cidex log kept at the cleaning station this was not done. "Test the solution prior to each use to assure that the glutaraldehyde concentration is above its MEC (minimum effective concentration)." According to the Cidex log kept at the cleaning station this was not done. According to The Association for the Advancement of Medical Instrumentation (ANSI/AAMI) ST58:2005 ... "It must be realized that the actual reuse life can be shorter, as it depends upon factors such as the cleanliness of	C 337	will be to have random cultures done of the previously sterilized equipment between uses to monitor for growth of bacteria. All of these quality improvement processes will be presented quarterly to the quality improvement committee and to the governing board. These corrective measures will be completely implemented by 06/05/2010, and monitored by the Director of Nursing for the hospital to ensure compliance. 2. The CS technician had training in packaging, sterilization, labeling and QI indicators for disinfection of the facilities instruments. She was trained at Portneuf Medical center on 05/27/2010. The facility has ordered biological testing indicators for use when autoclaving so that each time autoclaving is done it will have a chemical and biological indicator to ensure that the parameters necessary for sterilization are met. She has developed a log to accompany each load of sterilizing done in the autoclave indicating the results of the biological and chemical test. All previously packaged instruments that were autoclaved before the facility used biological indicators in conjunction with the chemical indicators will be re-sterilized. All instruments sterilized will	

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C 337	Continued From page 70 the item being disinfected, bioburden left on the device, residual detergents, temperature and pH of the solution, and the environmental temperature in the area." Further the ANSI/AAMI stated,"Best practices monitor the disinfectant solution with an appropriate test strip prior to each time it is used during the expected reuse life." This was not done as follows: In a review of the Cidex log on 5/05/10 at 12:53 PM, Cidex was activated on 2/24/09. Twenty-eight days from 2/24/09 would have been 3/24/09. Following manufacturer's recommendations, the Cidex should have been discarded on 3/24/09. It was documented the Cidex was discarded on 5/18/09. Patient #33 had a colonoscopy on 3/31/09. There was no documentation of testing of the Cidex solution before the disinfection process began. The Cidex was then activated on 5/19/09 and should have been discarded on 6/16/09. Instead the Cidex was discarded on 6/29/09. Patient #34 had a colonoscopy on 6/16/09. There was no documentation of testing of the Cidex solution before the disinfection process began. Patient #35 had a colonoscopy on 6/23/09. There was no documentation of testing of the Cidex solution before the disinfection process began. The Cidex was then activated on 7/21/09 and should have been discarded on 8/18/09. Instead the Cidex was discarded on 9/06/09. However, a notation of "tested with pass on 9/01/09," was	C 337	be labeled with date and load number. The log will include the load number, contents and date, so event related monitoring can occur to recall suspected contaminated equipment and to pull outdated stock. This corrective process will be completed by 06/08/2010. The corrective process will be monitored by the Director of Quality Improvement for continued compliance, and all quality improvement data for the Central Processing Unit will be presented at the quarterly quality improvement meeting and to the governing board. 3. All patients who are seen through the GI clinic will have a post procedure follow up evaluation by phone between 24 and 72 hours following a procedure. The GI clinic technician will make the telephone calls within 24 to 72 hours following a procedure, and the responses will be documented on a GI laboratory patient phone questionnaire. In addition all patients seen in the GI clinic will be sent a patient satisfaction survey that contains quality indicators. These corrective actions will be completed and in use by 06/08/2010. These performance improvement projects will be monitored for compliance by the quality improvement manager, and the performance improvement data will be presented quarterly to the quality	

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C 337	Continued From page 71 documented on the log. The next documented activation of Cidex was 9/06/09 with another notation of "test with pass on 10/14/09." The next discarded date recorded was 12/07/09. The Cidex should have been discarded on 10/04/09. Patient #36 had a colonoscopy on 11/03/09. There was no documentation of testing of the Cidex solution before the disinfection process began. Documentation on the Cidex log shows activation 2/23/10 with discard recorded as 4/27/10. Twenty-eight days from 2/23/10 would have been 3/23/10. Patient #37 had an EGD on 4/05/10. An EGD is a visualization of the esophagus, stomach, and duodenum with a scope. There was no documentation of testing of the Cidex solution before the disinfection process began prior. Patient #38 had an EGD on 4/20/10. There was no documentation of testing of the Cidex solution before the disinfection process began. Patient #39 had a colonoscopy on 4/27/10. There was no documentation of testing of the Cidex solution before the disinfection process began. In an interview 5/05/10 at 12:45 PM, with the CNA, ER/Endoscopy Technician, who does all of the endoscopy cleaning, stated the person who trained him told him as long as test strip comes out positive there is no need to change the solution. No documentation of this training was found.	C 337	improvement committee and the governing board. 4. Physical therapy department and Occupational therapy department have both developed performance improvement projects. The physical therapy department has developed a policy to ensure that progress notes for all patients receiving physical therapy are on the chart within 48 hours. The department is monitoring all notes to ensure they are put in the patients chart within 48 hours. The occupational department has developed a performance improvement project to monitor all inpatients and swing bed patients in the hospital for orders for occupational therapy and ensure that ordered evaluations and treatments are begun within 24 hours of the order being received. Both the Physical therapy department and the Occupational therapy department will attend the quarterly Quality Improvement Committee meetings, and present data regarding the performance improvement projects. This data will also be presented to the governing board quarterly. The Quality Improvement Coordinator will be responsible to ensure that Physical therapy and Occupational therapy departments attend Quality Improvement Committee meetings and have ongoing	

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C 337	Continued From page 72 Further, he confirmed all dates documented on the Cidex log were correct as recorded. The CAH's Central Service Policy #6, not dated or signed, states,"All equipment used at [CAH's name] will be cleaned/sterilized as appropriate to its manufacture and use." According to the CNA/ER/Endoscopy technician's statement and the observed Cidex log this was not done. The QA failed to ensure the sterilization procedures was included in its QA program. The QA's failure to ensure that sterilization procedures had QI and PIPs resulted in poor sterilization practices. 2. The American National Standard dated 2006, stated "Biological indicators should be used...for routine sterilizer efficacy monitoring at least weekly, but preferably every day that the sterilizer is in use." A biological indicator (spore test) is a device used to monitor the sterilization process of the autoclave. It consists of a standardized population of bacterial spores. A biological indicator monitors the autoclaving cycle and ensures that all the parameters necessary for sterilization were present during the autoclaving process. During a tour of the CAH's Sterile Processing unit on 5/4/10 starting at 2:43 PM, it was noted that instruments used for patient care were autoclaved. The CAH's Central Service Policy #3, Resterilization of Supplies, and Policy #12, Resterilization of Packs and Trays, last reviewed on 1/17/08, stated an Attest was to be used with	C 337	performance improvement projects for their departments.	

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C 337	Continued From page 73 every load autoclaved. This policy was not followed. Examples include: The CAH's "ATTEST Biological Monitoring System for Steam Sterilization" log sheets, documented the last time an Attest was run was 12/21/07. The CAH did use a chemical indicator with each load that was autoclaved. However, without the use of weekly biological indicators, in conjunction with the chemical indicators, the facility could not ensure that the parameters necessary for sterilization were present. The DON was present during the tour. She did not know what an Attest was. On 5/05/10 starting at 9:25 AM, the CS Technician was interviewed. She stated that she was trained 18 years ago on how to autoclave instruments. However, she stated that she had not preformed autoclaving for many years and stated she started her current CS job on 1/04/10. She stated she did not know what an Attest was nor how to run one. On 5/05/10 starting at 9:30 AM, the CS Director was interviewed. She confirmed the CS/SP units did not have any QI projects, QI indicators or PIPs. She stated she did not know what an Attest was for. The QI program failed to evaluate the quality and appropriateness of the Sterile Processing unit and develop quality indicators and PIPs. 3. During a tour of the CAH's Sterile Processing unit on 5/04/10 starting at 2:43 PM, and the ED on 5/04/10 starting at 3:00 PM, it was noted that more than 100 instruments, such as clamps,	C 337		

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C 337	Continued From page 74 scissors and tweezers, that were autoclaved did not have a sterilizer load number, or a date written on the package as to when they were autoclaved. Additionally, the Sterile Processing unit did not have a log book that contained sterilizer load number, dates or contents of autoclaved instruments. This was confirmed by the DON during the observations. This had the potential to effect the CAH's ability to recall suspected contaminated equipment and pull outdated stock. The CAH's Central Service Policy #1, Objectives of Central Services, last reviewed on 1/17/08, stated, "Central Services will maintain an accurate record of the various processes of cleaning, disinfecting, and sterilization." The CAH's Central Service Policy #9, Expiration Dates, last reviewed on 1/17/08 stated, "Dates will be marked in indelible ink and placed on package side which will face the person opening the package." The CAH's Central Service Policy #8, Shelf life of packaged materials, last reviewed on 1/17/08, stated the following: "Autoclave tape, marked with the expiration date is to be placed on autoclaved packages." " Single wrapped items will have a shelf life of no greater than one month." " Double wrapped packs, basins and linens will have a shelf life of no greater than three months." " Items wrapped in plastic will have a shelf life of no greater than six months."	C 337		

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C 337	Continued From page 75 " All outdated items will be removed from service area on day of expiration and returned to CS." These policies were not followed. The QI program failed to evaluate the quality and appropriateness of the Sterile Processing unit. This resulted in the inability of the QI program to develop quality indicators and PIPs. 4. The CAH's Post Procedure Follow-Up Evaluation for the GI Laboratory, that was not documented as being approved by the Governing Body stated, "A Post Procedure Follow-up Evaluation by phone will be made by the GI Laboratory staff between 24 and 72 hours following a procedure." The telephone call was to be documented on a GI LABORATORY PATIENT PHONE QUESTIONNAIRE. The questions staff were to inquire about included if the patient had experienced any nausea, vomiting, dizziness, diarrhea, IV site inflammation and other quality indicators. During an interview with the Director of Quality Assurance on 5/05/10 starting at 9:15 AM, she stated she could not remember the last time that the GI Laboratory had collected quality indicators or had a PIP. Additionally, the GI Laboratory had a PATIENT SATISFACTION SURVEY that was to be sent to all GI Laboratory patients that contained quality indicators. During an interview with the Director of Quality Assurance on 5/05/10 starting at 9:15 AM, she stated that she was unaware when the patient satisfaction survey had been developed or the last time it was implemented.	C 337		

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C 337	Continued From page 76 The QI program failed to gather the GI Laboratory's quality indicators and develop PIPs. 5. Quality Improvement Committee Meeting Minutes were reviewed for 2009 through the first Quarter of 2010. The Meeting Minutes did not document that OT had attended the meetings or that quality indicators and PIPs had been developed for OT services. Additionally, in 04/14/09, the Quality Improvement Committee Meeting Minutes stated that Physical Therapy was to "work on ensuring they have orders documented for all treatments." This project was started in 5/07. Refer to C402 for the failure of the QA department to ensure PT and OT staff had documented evidence they had provided specialized rehabilitative services per physician's orders. The QI program failed to gather PT quality indicators and develop PIPs. The QI program failed to evaluate the quality and appropriateness of OT services. This resulted in the inability of the QI program to develop quality indicators and PIPs.	C 337		
C 381	485.645(d)(3) RESTRAINTS [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:] Resident behavior and facility practices - restraints (§483.13(a)): "The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical	C 381	**C381 485.641(b)(1) RESTRAINTS** The restraint policy and procedure was updated to include bed rails as a restraint, with all the restrictions and guidelines associated with all restraints, and that using 4 bed rails cannot be used without an order from the physician, and without monitoring if the order is received and 4	**11June10**

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C 381	Continued From page 77 symptoms." This STANDARD is not met as evidenced by: Based on staff interview, review of hospital policies and observations, it was determined the CAH failed to ensure restraint measures were only used to ensure patient safety for 1 of 2 patients (#14), who were observed. This resulted in the patient being restrained as a convenience, rather than to treat the patient's medical symptoms. The findings include: Patient #14 was a 95-year-old female admitted on 4/29/10 for continued care following a hip fracture. Patient #14 was observed to be confused and often tried to get out of bed. A Quality Management Memo, dated 5/01/10, stated Patient #14 had fallen out of the bed at 4:45 AM. On 5/03/10 at 3:00 PM, Patient #14 was observed in bed with all four bed rails up. The CAH's Restraint policy that was not documented as being approved by the Governing Body, defined a physical restraint as any device that restricts the freedom of movement. However the policy failed to identify 4 bed rails as a restraint. On 5/03/10 at 3:05 PM, Patient #14's LPN was asked why all four bed rails were up. She stated that Patient #14 had Alzheimers and the side rails helped keep her in bed. She acknowledged this was a restraint and put 2 of the four bed rails down. The CAH failed to ensure staff did not use restraints as a substitute for supervision for	C 381	bed rails used. All hospital staff was in-serviced regarding the policy change between 05/25/2010 and 05/28/2010. This corrective action was implemented on 05/28/2010. Education regarding the use of restraints will continue on a yearly basis for all staff. The Director of Nursing for the hospital will be responsible to ensure the continuation of this corrective action.	

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C 381	Continued From page 78 Patient #14.	C 381		
C 399	485.645(d)(6) DISCHARGE PLANNING [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter: Comprehensive assessment, comprehensive care plan, and discharge planning (§483.20(b), (k), and (l), except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b)).] Discharge summary ((§483.20(l)) "When the facility anticipates discharge a resident must have a discharge summary that includes- (1) A recapitulation of the resident's stay; (2) A final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and (3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment." This STANDARD is not met as evidenced by: Based on staff interview and review of patient records and policies, it was determined the CAH failed to ensure 1 of 2 discharged Swing Bed patients (#12), whose records were reviewed, contained a comprehensive discharge summary.	C 399	**C 399 485.645(d)(6) DISCHARGE PLANNING** A discharge summary form was developed to assist the physicians with the development of a discharge summary and it includes: A recapitulation of the resident's stay, a final summary of the resident's status, and a post-discharge plan of care. The medical staff of the facility was in-serviced regarding the addition of the form and the necessary components of a discharge summary on 05/12/2010. This corrective action was implemented on 05/12/2010 and will be monitored by the Medical Records Director for continued compliance.	**11June10**

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C 399	Continued From page 79 This had the potential to negatively impact coordination and quality of patients post care. The findings include: The CAH's Rules and Regulations of the Medical Staff (Bi-Laws), dated 09/06 stated, a discharge summary should contain brief notations concerning medical complaint, history, physical findings, pertinent lab and radiology findings, treatments including complications, hospital course, condition on discharge and follow-up instructions and treatment. Patient #12 was a 71-year-old female who was admitted to the CAH on 2/26/10 for post care after a total knee surgery. She was discharged on 3/10/10. Patient #12's discharge summary was hand written on the record's inpatient face sheet that had the address and the billing information for Patient #12. The discharge summary did not include history, physical findings, pertinent lab and radiology findings, treatments including complications, hospital course, or condition on discharge. On 5/04/10 at 2:45 PM, the CAH's HIS manager was interviewed. She reviewed Patient #12's discharge summary and stated that the lack of documentation was typical for Patient #12's physician. On 5/06/10 at 3:35 PM, the CAH's CEO was interviewed. He stated the physician who took care of Patient #12 would not dictate his work. He stated that documentation had been an ongoing issue with the physician and he was unsure how to enforce compliance.	C 399		

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C 399	Continued From page 80 The CAH failed to ensure discharged Swing Bed patients contained a comprehensive discharge summary.	C 399		
C 402	485.645(d)(7) SPECIALIZED REHAB SERVICES [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:] Specialized rehabilitative services (§483.45 of this chapter): "(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must- (1) Provide the required services; or (2) Obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services." This STANDARD is not met as evidenced by: Based on staff interview and review of patient records and policies, it was determined the CAH failed to ensure 2 of 2 current Swing Bed patients (#14 and #15), had documented evidence they had received specialized rehabilitative services per physician's orders. The failure to document or provide specialized rehabilitative services had the potential to inhibit coordination of patient care	C 402	**C 402 485.645(d)(7)** **SPECIALIZED REHAB SERVICES** **11June10** The physical therapy department developed a policy that all evaluations and rehabilitative progress notes are to be in the patient's chart within 48 hours of the time of service. In addition the department has begun a quality improvement project monitoring that all rehab progress notes are in the patient chart within 48 hours. The data they collect will be presented to the quality improvement committee and the governing board quarterly. This corrective measure was implemented 05/24/2010 and will be monitored by the Physical Therapist to ensure compliance. The admission form for swingbed patients is being updated to include a section where the admitting nurse can initial that evaluations were ordered. Oncoming staff and management review can then determine immediately if all therapies were ordered. Furthermore the Occupational therapy department is conducting a performance improvement project of	

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	131304	A. BUILDING _____ B. WING _____	05/05/2010

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C 402	Continued From page 81 between disciplines. The findings include: The HIS director was interviewed on 5/04/10 starting at 1:30 PM. She stated that the CAH did not have a policy in place to direct staff as to when their evaluations and progress notes were to be recorded in the patient's record. 1. Patient #14 was a 95-year-old female admitted on 4/29/10 for continued care following a hip fracture. Patient #14's physician had ordered PT five times a week and an OT evaluation on 4/29/10. Patient #14's record was reviewed on 5/03/10. The record contained no documented evidence that PT had evaluated Patient #14 or had been providing PT five times a week. Additionally, the record contained no documented evidence that OT had evaluated Patient #14. On 5/03/10 at 2:17 PM, an RN called the OT/PT clinic to see if they had evaluated and were treating Patient #14. She stated that PT had evaluated Patient #14 and was treating her. However, she stated it was often that the Physical Therapist did not "turn in his evaluations and notes." She further stated that OT had not received the order to evaluate Patient #14 and that was why it was not done. The facility failed to ensure specialized rehabilitative services were provided and documented. 2. Patient #15 was an 83-year-old male admitted on 4/21/10 for generalized ataxia (a neurological sign and symptom consisting of gross lack of coordination of muscle movements) and probable stroke. Patient #15's physician had ordered PT seven times a week. Patient #15's record was	C 402	monitoring the hospital swingbed patients to ensure that if Occupational therapy is ordered on a patient their department receives the order to provide services within 24 hours. The results of the performance improvement project will be presented to the quality improvement committee and the governing board quarterly. This corrective action was implemented on 05/24/2010 and is being monitored by Occupational therapy for compliance.	

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C 402	Continued From page 82 reviewed on 5/03/10. The record contained no documented evidence that PT had evaluated Patient #14 or had been providing PT seven times a week. On 5/03/10 starting at 2:10 PM, a PTA was interviewed. She stated that PT had evaluated Patient #15 and was treating him. However, she stated that the Physical Therapy department did not "turn in their evaluations and notes for an extended period of time." She further stated that she had worked with Patient #15 two times a week but could not provide documented evidence that anyone had provided PT services the other 5 days a week. The CAH failed to ensure PT and OT services had provided and/or documented specialized rehabilitative services per physician's orders.	C 402		

Bureau of Facility Standards

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B 000	16.03.14 Initial Comments The following deficiencies were cited during the licensure survey of your Critical Access Hospital and the Swing bed unit. Surveyors conducting the survey were: Patrick Hendrickson, RN, HFS, Team Leader Susan Costa, RN, HFS Gary Banister, RN, HFS	B 000		
BB115	16.03.14.200.01 Governing Body and Administration 200. GOVERNING BODY AND ADMINISTRATION. There shall be an organized governing body, or equivalent, that has ultimate authority and responsibility for the operation of the hospital. (10-14-88) 01. Bylaws. The governing body shall adopt bylaws in accordance with Idaho Code, community responsibility, and identify the purposes of the hospital and which specify at least the following: (10-14-88) a. Membership of Governing Body, which consist of: (12-31-91) i. Basis of selecting members, term of office, and duties; and. (10-14-88) ii. Designation of officers, terms of office, and duties. (10-14-88) b. Meetings, (12-31-91) i. Specify frequency of meetings. (10-14-88) ii. Meet at regular intervals, and there is an	BB115	**BB115 16.03.14.200.01 GOVERNING BOARD AND ADMINISTRATION** BB115 Governing Body and Administration Please see documentation for citation C240 on page 5 of 83 on form CMS-2567. RECEIVED JUN - 7 2010 FACILITY STANDARDS	**11June10**

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: CEO/ADMINISTRATOR

(X6) DATE: 1 JUNE 2010

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BB115	Continued From page 1 attendance requirement. (10-14-88) iii. Minutes of all governing body meetings shall be maintained. (10-14-88) c. Committees, (12-31-91) i. The governing body officers shall appoint committees as appropriate for the size and scope of activities in the hospitals. (10-14-88) ii. Minutes of all committee meetings shall be maintained, and reflect all pertinent business. (10-14-88) d. Medical Staff Appointments and Reappointments; (12-31-91) i. A formal written procedure shall be established for appointment to the medical staff. (10-14-88) ii. Medical staff appointments shall include an application for privileges, signature of applicant to abide by hospital bylaws, rules, and regulations, and delineation of privileges as recommended by the medical staff. The same procedure shall apply to nonphysician practitioners who are granted clinical privileges. (10-14-88) iii. The procedure for appointment and reappointment to the medical staff shall involve the administrator, medical staff, and the governing body. Reappointments shall be made at least biannually. (10-14-88) iv. The governing body bylaws shall approve medical staff authority to evaluate the professional competence of applicants, appointments and reappointments, curtailment of	BB115		

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BB115	Continued From page 2 privileges, and delineation of privileges. (10-14-88) v. Applicants for appointment, reappointment or applicants denied to the medical staff privileges shall be notified in writing. (10-14-88) vi. There shall be a formal appeal and hearing mechanism adopted by the governing body for medical staff applicants who are denied privileges, or whose privileges are reduced. (10-14-88) e. The bylaws shall provide a mechanism for adoption, and approval of the organization bylaws, rules and regulations of the medical staff. (10-14-88) f. The bylaws shall specify an appropriate and regular means of communication with the medical staff. (10-14-88) g. The bylaws shall specify departments to be established through the medical staff, if appropriate. (10-14-88) h. The bylaws shall specify that every patient be under the care of a physician licensed by the Idaho State Board of Medicine. (10-14-88) i. The bylaws shall specify that a physician be on duty or on call at all times. (10-14-88) j. The bylaws shall specify to whom responsibility for operations, maintenance, and hospital practices can be delegated and how accountability is established. (10-14-88) k. The governing body shall appoint a chief	BB115		

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BB115	Continued From page 3 executive officer or administrator, and shall designate in writing who will be responsible for the operation of the hospital in the absence of the administrator. (10-14-88) l. Bylaws shall be dated and signed by the current governing body. (10-14-88) m. Patients being treated by nonphysician practitioners shall be under the general care of a physician. (10-14-88) This Rule is not met as evidenced by: Refer to C-240 as it relates to the Governing Body's failure to ensure it had developed and maintained an effective organizational structure.	BB115		
BB124	16.03.14.200.10 Quality Assurance 10. Quality Assurance. Through administration and medical staff, the governing body shall ensure that there is an effective, hospital-wide quality assurance program to evaluate the provision of care. The hospital must take and document appropriate remedial action to address deficiencies found through the program. The hospital must document the outcome of the remedial action. (10-14-88) This Rule is not met as evidenced by: Refer to C-330 as it relates to the failure of the facility to ensure it had the developed and implemented a comprehensive data driven QA program.	BB124	**BB124 16.03.14.200.10 QUALITY ASSURANCE** BB124 Quality Assurance Please see documentation for citation C330 on page 66 of 83 on form CMS-2567.	**11June10**
BB173	16.03.14.310.01 Director of Nursing Services 310. NURSING SERVICE.	BB173	**BB173 16.03.14.310.01**	

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BB173	Continued From page 4 There shall be an organized nursing department with a plan that delineates authority, responsibility and duties of each category of nursing personnel, and a functional structure for cooperative planning and cooperation. An organizational chart shall be in the nursing service office and in all policy manuals. Job descriptions shall be available and in use which delineate responsibilities, functions or duties, and qualifications for each category of nursing positions. (10-14-88) 01. Director of Nursing Services. The nursing service shall be under the overall direction of a qualified registered nurse with education and experience commensurate with size and complexity of the hospital whose duties are as follows: (10-14-88) a. To organize, coordinate, and evaluate nursing service functions and staff; and (10-14-88) b. To be responsible for development and implementation of policies and procedures as they relate to care of patients; and (10-14-88) c. To select, promote, and terminate nursing staff; and (10-14-88) d. To establish a procedure to insure staff licenses are valid and current. (10-14-88) This Rule is not met as evidenced by: Refer to C-297 as it relates to the failure of the DNS to ensure staff followed pharmacy medication administration policies and standards of practice when administering medications to patients.	BB173	**DIRECTOR OF NURSING SERVICES** **11June10** BB173 Director of Nursing Services Please see documentation for citation C297 on page 57 of 83 on form CMS-2567.	

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BB221	Continued From page 5	BB221		
BB221	16.03.14.330.01 Organization and Supervision 330. PHARMACY SERVICE. The hospital shall provide an organized pharmaceutical service that is administered in accordance with accepted professional principles and appropriate federal, state, and local laws. (10-14-88) 01. Organization and Supervision. Pharmacy services shall be under the overall direction of a pharmacist who is licensed in Idaho and is responsible for developing, coordinating, and supervising all pharmaceutical services in the hospital. (10-14-88) a. The director of the pharmaceutical service, whether a full, part-time or a consultant member of the staff, shall be responsible to the chief executive officer or his designee. (10-14-88) b. The pharmacist shall be responsible for the supervision of the hospital drug storage area in which drugs are stored and from which drugs are distributed. (10-14-88) c. If trained pharmacy assistants, pharmacy students, or pharmacy interns are employed, they shall work under the direct supervision of a pharmacist. (10-14-88) d. If the director of the pharmaceutical service is part-time, sufficient time shall be provided by the pharmacist to fulfill the responsibilities of the director of pharmaceutical services. (10-14-88) e. The director of the pharmaceutical service shall be responsible for maintaining records of the transactions of the pharmacy as required by law and as necessary to maintain adequate	BB221	**BB221 16.03.14.330.01 ORGANIZATION AND SUPERVISION** BB221 Organization and Supervision Please see documentation for citation C276 on page 41 of 83 on form CMS-2567.	**11June10**

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BB221	Continued From page 6 control and accountability of all drugs. This includes a system of control and records for the requisitioning and dispensing of drugs and supplies to nursing units and to other department/services of the hospital, as well as records of all prescription drugs dispensed to the patient. (10-14-88) f. The pharmacist shall periodically check drugs and drug records in all locations in the hospital where drugs are stored, including but not limited to nursing stations, emergency rooms, outpatient departments, operating suites. (10-14-88) This Rule is not met as evidenced by: Refer to C-276 as it relates to the CAH's failure to follow established standards of practice and policies in the management of medications.	BB221		
BB283	16.03.14.360.12 Record Content 12. Record Content. The medical records shall contain sufficient information to justify the diagnosis, warrant the treatment and end results. The medical record shall also be legible, shall be written with ink or typed, and shall contain the following information: (10-14-88) a. Admission date; and (10-14-88) b. Identification data and consent forms; and (10-14-88) c. History, including chief complaint, present illness, inventory of systems, past history, family history, social history and record of results of physical examination and provisional diagnosis that was completed no more than seven (7) days before or within forty-eight (48) hours after admission; and (5-3-03)	BB283	**BB283 16.03.14.360.12 RECORD CONTENT** BB283 Record Content Please see documentation for citation C267 on page 27 of 83 and citation C399 on page 79 of 83 and citation C402 on page 81 of 83 on form CMS-2567.	11June10

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BB283	Continued From page 7 d. Diagnostic, therapeutic and standing orders; and (10-14-88) e. Records of observations, which shall include the following: (10-14-88) i. Consultation written and signed by consultant which includes his findings; and (10-14-88) ii. Progress notes written by the attending physician; and (10-14-88) iii. Progress notes written by the nursing personnel; and (10-14-88) iv. Progress notes written by allied health personnel. (10-14-88) f. Reports of special examinations including but not limited to: (10-14-88) i. Clinical and pathological laboratory findings; and (10-14-88) ii. X-ray interpretations; and (10-14-88) iii. E.K.G. interpretations. (10-14-88) g. Conclusions which include the following: (10-14-88) i. Final diagnosis; and (10-14-88) ii. Condition on discharge; and (10-14-88) iii. Clinical resume and discharge summary; and (10-14-88) iv. Autopsy findings when applicable. (10-14-88)	BB283		

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BB283	Continued From page 8 h. Informed consent forms. (10-14-88) i. Anatomical donation request record (for those patients who are at or near the time of death) containing: (3-1-90) i. Name and affiliation of requestor; and (3-1-90) ii. Name and relationship of requestee; and (3-1-90) iii. Response to request; and (3-1-90) iv. Reason why donation not requested, when applicable. (3-1-90) This Rule is not met as evidenced by: Refer to C-267 as it relates to the CAH's failure to ensure records contained completed transfer forms when patients were transferred to other facilities. Refer to C-399 as it relates to the CAH's failure to ensure records contained a comprehensive discharge summary. Refer to C-402 as it relates to the CAH's failure to ensure patient records included all PT and OT evaluations and progress notes.	BB283		
BB321	16.03.14.380.08 Staff Training and Education 08. Staff Training and Education. There shall be evidence of continuing education and training for the staff. (10-14-88) This Rule is not met as evidenced by: Refer to C-337 for the failure of the CAH's Surgery Services to properly in-service SP	BB321	**BB321 16.03.14.380.08 STAFF TRAINING AND EDUCATION** BB321 Staff Training and Education	**11June10**

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BB321	Continued From page 9 employees.	BB321	Please see documentation for citation C337 on page 69 of 83 on form CMS-2567.	

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
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May 24, 2010

Dallas Clinger
Harms Memorial Hospital
P O Box 420
American Falls, ID 83211

FILE COPY

Provider #131304

Dear Mr. Clinger:

On **May 5, 2010**, a complaint survey was conducted at Harms Memorial Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004558

ALLEGATION #1:

Patients were not provided informed consent before procedures.

FINDINGS:

An unannounced complaint survey was conducted on May 3, 2010 through May 6, 2010. Clinical records and facility emergency department/outpatient logs were reviewed. Staff interviews were conducted.

Five records of patients who had outpatient endoscopic procedures were reviewed for evidence of informed consent. All records contained the same verbiage depicting the procedure.

One record, contained a, "AUTHORIZATION FOR AND CONSENT TO SURGERY OR SPECIAL DIAGNOSTIC OR THERAPEUTIC PROCEDURES," that documented the procedure as "Colonoscopy with possible biopsy/polypectomy." The "CONSENT FOR THE

ADMINISTRATION OF INTRAVENOUS CONSCIOUS SEDATION," signed by the patient and dated May 21, 2008, at 6:35 a.m., documented the patient did,"...acknowledge that my doctor has explained that I will have a diagnostic procedure."
In an interview with the physician, on May 4, 2010, at 8:55 a.m., he confirmed all patients were informed of the purpose, risks, and possible complications of procedures.

The Critical Access Hospital's (CAH) "AUTHORIZATION FOR AND CONSENT TO SURGERY OR SPECIAL DIAGNOSTIC OR THERAPEUTIC PROCEDURES" and "CONSENT FOR THE ADMINISTRATION OF INTRAVENOUS CONSCIOUS SEDATION," were filled out consistently completed and it could not be determined that patients were not informed before procedures were performed.

It could not be determined the CAH failed to provide patients information before having procedures, therefore the allegation was unsubstantiated.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Patients' grievances were not properly responded to.

FINDINGS:

An unannounced complaint survey was conducted on May 3, 2010 to May 6, 2010. Hospital policies & procedures and the grievance log was reviewed. Interviews were conducted.

The CAH's grievance log documented five grievances, from January 2008 to May 3, 2010.

In a phone interview conducted on May 4, 2010, at 8:30 a.m., a patient stated that she had written a letter and received a written response from the CEO/Administrator, dated March 5, 2010. The CAH had no documentation of this grievance.

Review of the Policy "COMPLAINT/GRIEVANCE REPORTING AND INVESTIGATION," dated March 22, 2005, documented that once a complaint had been received by the CAH, "The Grievance/Complaint Log will indicate the date and nature of final resolution."

The administrator confirmed in an interview conducted May 4, 2010, at 3:25 p.m., that there was no documentation of this complaint in the Grievance/Complaint Log.

While the patient's grievance was responded to, a deficiency was cited at 42 CFR Part 485.627(A)Q 241, for the failure of the Governing Body to ensure the CAH had followed the established Complaint/Grievance policy and logged the grievance.

CONCLUSIONS:
Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care

SLYVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/sp